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TEXAS A&M UNIVERSITY - CORPUS CHRISTI
College of Nursing and Health Sciences
NURS 4564 NURSE AS PROVIDER OF CARE TO
PSYCHIATRIC/CHEMICAL DEPENDENCY PATIENTS
Fall Semester 2011

Faculty: Carmen Hernandez MSN, RN
Office Hours: Monday 9-11 & 1-3 Tuesday 9-11 Other times by appointment
Office Phone: 825-5614
E-mail: carmen.hernandez@tamucc.edu
Location: Island Hall 333
Credits: 5 credit hours

Clinical faculty: Kathy Deis MSN, RN
Office Phone: 361.825.3087
Office: Island Hall 331

Clinical faculty: Carmen Hernandez MSN, RN
Office Phone: 361.825.5614
Office: Island Hall 33

Clinical faculty: Susan Reinhart MS, RN
Office Phone: 361.825.3957
Office: Island Hall 344

Course Description: Emphasis is on the nurse as provider of care to individuals, families and groups experiencing psychiatric/mental health problems. Theoretical foundations for the practice of psychiatric/mental health nursing and theoretical frameworks for understanding human behavior are studied.

Course Objectives with examples of outcome criteria:

1. Examine theoretical frameworks of human behavior and development that explain normal and abnormal behavior.
   1.1 Compare and contrast the concepts of mental health and mental illness.
   1.2 Interpret the assumptions and key concepts of the neuron-chemical-biologic, psychoanalytic, behavioral and social-interpersonal frameworks.
   1.3 Describe the implications each framework has for psychiatric nursing practice
   1.4 Recognize that the knowledge of growth and development is an integral component of nursing assessment and nursing diagnosis.
1.5 Summarize theories that purport to explain stress.

2. Analyze nursing theory as a basis for psychiatric nursing.
   2.1 Evaluate the usefulness of selected contemporary nursing theories for organizing data and guiding the practice of psychiatric nursing.
   2.2 Comprehend key concepts in selected contemporary nursing theories.
   2.3 Apply theories to clinical practice and integrate into clinical journal.

3. Relate the usefulness of research in psychiatric nursing.
   3.1 Identify critical issues associated with the application of nursing research to psychiatric nursing practice.
   3.2 Predict directions for future psychiatric nursing research.
   3.3 Utilize psychiatric nursing research in nursing practice.
   3.4 Participate in the examination and application of current psychiatric research in classroom exercises.
   3.5 Evaluate the clinical care of patients in light of current psychiatric research.

4. Recall clinical modalities and psychiatric terminology as it relates to psychiatric/addictions nursing practice.
   4.1 Explain the psychopathology and neurochemistry of specific mental and addictive disorders.
   4.2 Describe the behavioral manifestations of specific mental and addictive disorders.
   4.3 Describe classes, properties, use and side effects of the major psychotropic medications.
   4.4 Relate the movement disorders caused by psychotropic drugs.
   4.5 Identify specific interventions for psychiatric and addictive disorders.
   4.6 Correlate DSM IV with the nursing process in providing care for patients with mental and addictive disorders.
   4.7 Identify factors affecting families of mentally ill and chemically dependent individuals.

5. Relate the legal, ethical, political, historical and cultural factors critical to the practice of psychiatric and addictions nursing.
   5.1 Relate the importance of psychiatric/addictions nursing assessment to legal, ethical and practice issues.
   5.2 Identify ethical dilemmas in psychiatric nursing.
   5.3 Recall critical historical elements associated with the development of psychiatric/addictions nursing.
   5.4 Discuss the relevance of cultural factors in psychiatric/addictions nursing practice.
   5.5 Describe the relationship between the legal and civil rights of mental health patients.
5.6 Relate the Texas Mental Health Code and its relevance to the practice of psychiatric nursing in Texas.
5.7 Evaluate the importance of State Mental Health Codes and the protection of the mentally ill.

6. Analyze the component of the caring-empathic relationship.
6.1 State the nature and goals of the caring-empathic relationship.
6.2 Identify common characteristics of the caring-empathic relationship.
6.3 Explain the nurse’s role and potential issues that may arise in each phase of the nurse-patient relationship.
6.4 Compare and contrast major theories of communication with psychiatric and chemical dependency patients.
6.5 Explain such strategies as boundaries, distance, self-disclosure, acceptance of gifts, limit setting, confrontation and use of touch with mentally ill and chemically dependent patients.
6.6 Relate a personal philosophy and values framework salient to the care of psychiatric and chemically dependent patients.

7. Accept responsibility for own learning.
7.1 Attend class regularly and in a timely manner.
7.2 Participate in classroom exercises, activities and discussions.
7.3 Select independent learning experiences related to own interests and needs.
7.4 Practice appropriate communication techniques in the classroom.
7.5 Evaluate progress in relation to objectives.
7.6 Apply critical thinking exercises to classroom discussion.
7.7 Complete assignments within designated time period and submit neatly prepared written work.

Required Textbooks:

Highly Recommended Textbook:

Learning Experiences and Teaching Methods:
Course objectives may be met through individual study using suggested resources, active involvement in classroom activities, formal and informal exchange of ideas with classmates and colleagues regarding specific topics as well as utilizing critical thinking skills. Consistent classroom attendance and participation is a requirement of this
course. Teaching methods include lecture, seminar, discussion, small group work, independent study of texts and library resources, computer-assisted instruction, audio-visual aids and the assignments listed below. While the professor will provide guidance and consultation, the student is responsible for identification of learning needs, self direction, seeking consultation and providing measurable demonstration of course objectives.

Student Class Rights and Responsibilities:

Students are:

1. Expected to respect the learning rights of others in the classroom, individual conversations, arriving to class late and studying for another class during classroom time is unacceptable behavior, disruptive and considered non-contributive to a positive learning environment. See College of Nursing policy on Academic Integrity and Professional Conduct

2. Expected to complete all required reading prior to each class period.

3. Written homework may be assigned at the discretion of the faculty. As a 5 semester credit course, faculty expect 10-12 hours of independent preparation and study each week, in addition to class time. Preparation for all classes includes assigned readings for the scheduled topics and completion of class assignments.

4. Permission to tape record must be obtained from each lecturer prior to class. Clinical examples or examples from clinical experiences are not to be recorded.

5. Children are NOT permitted in the classroom at any time. (See University Student Manual.)

CLASS POLICIES

Grading Policy

Successful completion of NURS 4564 requires the following:

1. Completion of the theoretical component: The test average (including the HESI final) must average a minimum of 75%. After the grade average on the four (4) exams meets an average of 75%, the Famous Person Presentation grade will be averaged in to achieve the final course grade. You must successfully complete clinical practicum to pass this course.

2. Clinical practice is the application of the theoretical component into the practice area. Preparation for clinical practice is required. Clinical performance is graded pass/fail and is evaluated on the basis of written clinical objectives. If the student fails clinical, he/she will receive an “F” in the course, regardless of the theory grade. If the student fails theory, he/she will receive an “F” in the course, regardless of the clinical grade. Theory is given a letter grade and if the student passes clinical, the course grade will be the grade achieved in theory. To pass the theory component the student must achieve a minimum average of 75%.
3. A HESI specialty exam will be given for this Course (see Course Schedule) and is **mandatory**. If HESI, the specialty exam is not taken, due to the student’s failure to attend the scheduled date and time, a grade for the Course will not be issued.

4. **School of Nursing Grading Scale**

   A  90-100  
   B  83-89  
   C  75-82  
   D  74-67  
   F  66 and below

5. **Evaluation Methods:**

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<td>Exam III</td>
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<td>HESI Exam</td>
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6. **Examination blue prints and Test Challenge forms are in Appendix C.**

7. **Class Participation:**

   Class participation is defined in the following manner:
   
   a. Regular and timely attendance at all scheduled classes – **coming in late is considered disruptive to the learning environment**; the issue will be addressed individually with the student and, if
necessary, the Policy on Academic Integrity and Professional Conduct will be instituted.

b. Participation in discussion of assigned classroom activities and classroom objectives.

c. Discussion and presentation of assigned objectives during classroom group work.

d. Implementation of assigned classroom activities.

e. Analysis of classroom lecture content, assigned scenarios and video presentations during class time.

f. **Cell phones are to be turned off during the class and examinations.** During exams cell phones must be put away and not accessed during the examination period.

**Missed Examinations:**

The student is permitted to miss only **ONE** examination of the **THREE** faculty generated examinations. Missing an examination MAY be due to a personal or professional emergency **ONLY**. If a student misses either Exam I, II or III a mean of the **TWO** exams taken is calculated to tabulate the score of the ONE missed exam. There are NO make-up examinations. Please notify faculty in advance if you must miss an exam. The student must have an **average of 75% on all four exams** to pass the theory portion of the course.

1) **The HESI exam is an exit exam and must be taken on the assigned day and time.** There is **NO make-up time allowed for the HESI exam.**

**Examination Guidelines:**

1) A blueprint for each exam is included in this syllabus – this blueprint was created by the baccalaureate faculty and approved for classroom use.

2) Students should bring a #2 pencil for exams – scantrons will be provided.

3) The final examination will be comprehensive.

4) Testable material is based on course, class and clinical objectives. Included are all required readings, lecture and discussion content, related material in the course syllabus, content covered by media presented in or required for class/clinical, power-point, and material given as handouts.

5) **A student self-paced, independent review Study Guide** has been provided as a **review of the lecture and text** material for each week as a way of assisting the student in studying for EXAMS I, II, & III and preparing for the HESI. **Students are expected to attend the class lectures and ask questions about the review material following the weekly lectures.** The purpose of this
independent, student directed review is to assist the student in taking the exams and studying for the HESI specialty exam.

6) Each student is responsible for making sure that he or she has completed the exam before the exam is turned in to the faculty. The student will not be allowed to retrieve his or her exam materials after turning it in.

7) Exam dates, times and locations are subject to change by the professor or the University.

8) To reinforce learning and to promote understanding of content, the following policies apply:
   a. Exam reviews will follow the exam with a key available for students to review their answers against the key. The following week the course faculty will review the test statistics and questions that were problematic.
   b. A TEST CHALLENGE FORM is provided in this syllabus to use in identifying questions that require clarification from the professor. ALL TEST CHALLENGE FORMS are to be signed by the student and turned in to the professor after the review of the examination.
   c. After review of the TEST CHALLENGE FORM, the professor will determine the appropriate action. Students will be informed in the next class if there has been a point re-allocation for specific questions.
   d. Students are expected to review their exams during the classroom time allocated for review.
   e. Students may further review Exams I, II & III during the professor's office hours or at a previously arranged appointment time. Student exam booklets will be shredded 3 weeks to the day after the examination.
   f. If time permits, the exams may be loaded and taken by computer.

**Class Cancellation:**
In the event that a class is canceled, the student is expected to do the readings and complete the objectives for that day. The content will still be included on course examinations.

**Course Changes:**
Elements of this syllabus may be changed at any time and the Course Calendar is subject to change.

**University Policies:**

**Academic Advising:** The College of Nursing and Health Sciences require that students meet with an Academic Advisor as soon as they are ready to declare a major. The Academic Advisor will set up a degree plan, which must be signed by the student, a faculty mentor, and the department chair. The College’s Academic Advising Center is
located in Faculty Center rooms 163 & 165, and advisors are Johanna DuBose 825.3748 and Angelica Santillan 825.2461.

**Students with Disabilities:** The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you believe you have a disability requiring an accommodation, please contact the Disability Services Office at 361.825.5816 or visit the office in Driftwood 101.

**Academic Honesty:** University students are expected to conduct themselves in accordance with the highest standards of academic honesty. Academic misconduct for which a student is subject to a penalty includes all forms of cheating, such as illicit possession of examinations or examination materials, forgery, or plagiarism. Plagiarism is the presentation of the work of another as one’s own work.

http://falcon.tamucc.edu/~students/JAffairs/ja_code_of_conduct_article3.htm

**Grade Appeal Process:** As stated in the College of Nursing and Health Sciences (CONHS) Handbook under section VII Policies and Procedures, a student that believes they have an academic grade appeal is encouraged to go through the CONHS academic review process prior to pursuing University Grade Appeal. See the handbook for the process.

As stated in University Rule 13.02.99.C2, Student Grade Appeals, a student who believes that he or she has not been held to appropriate academic standards as outlined in the class syllabus, equitable evaluation procedures, or appropriate grading, may appeal the final grade given in the course. The burden of proof is upon the student to demonstrate the appropriateness of the appeal. A student with a complaint about a grade is encouraged to first discuss the matter with the instructor. For complete details, including the responsibilities of the parties involved in the process and the number of days allowed for completing the steps in the process, see University Rule 13.02.99.C2, Student Grade Appeals, and University Procedure 13.02.99.C2.01, Student Grade Appeal Procedures. These documents are accessible through the University Rules Web site at http://www.tamucc.edu/provost/university_rules/index.html. For assistance and/or guidance in the grade appeal process, students may contact the Office of Student Affairs.

**Dropping a Class:** I hope that you never find it necessary to drop this or any other class. However, events can sometimes occur that make dropping a course necessary or wise. Please consult with me before you decide to drop to be sure it is the best thing to do. Should dropping the course be the best course of action, you must initiate the process to drop the course by going to the Student Services Center and filling out a course drop form. Just stopping attendance and participation WILL
NOT automatically result in your being dropped from the class. April 1st is the last day to drop a class with an automatic grade of “W” this term.

Preferred method of scholarly citations: APA
## COURSE SCHEDULE

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<td>Exam III – Statistical Review Famous Persons Presentations</td>
<td>Statistical Review Student Presentations</td>
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<td>Famous Persons Presentations</td>
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WEEKLY STUDY GUIDE ASSIGNMENTS
Fall 2011

Independent Review for Exams and HESI

WEEK #1: Discuss the legal/ethical concepts critical to psychiatric nursing care
Complete the three legal/ethical case studies in Appendix A and be prepared to discuss in class
Review the ethical concepts in Appendix B
Define OPC, voluntary and involuntary treatment*
Discuss Duty to Disclose*
Discuss ethical concerns in psychiatric nursing related to assault, battery and false imprisonment
Identify patient rights with special focus on least restrictive environment, confidentiality and right to refuse.*
**Role of the psychiatric nurse**

Name two important functions of the psychiatric nurse and support with rationale

Describe the role appropriate behavior of the psychiatric nurse – Detached concern*

Identify steps in the mental status examination.

Discuss elements of the mental status exam*

Assessment of affect*

Psychiatric nursing assessment*

Socializing role of the nurse*

Contracting for care*

Advocacy role of the nurse*

**Define the purpose of the following therapeutic strategies:**

Somatic therapy

Cognitive therapy

Reality therapy*

Therapeutic confrontation*

Behavior therapy

Supportive therapy

Empathic therapy *

Group therapy

Didactic group therapy

Process group therapy

Milieu therapy and the management of the milieu*

Nurse-patient individual therapy

**Conceptual Models**

Discuss the importance of the conceptual models that provide theoretical frameworks for therapeutic interventions*

**WEEK #2:** Identify the strategies for psychiatric nursing assessment

Presenting problem

Physical dimension

General Appearance

Body Image

Affect
Discuss the critical elements related to psychotropic drug therapy

Answer the following objectives:

1. Describe the biochemical relationship between parkinsonism and extra pyramidal effects.
2. Define akathisia, anticholinergic effects, dyskinesia, dystonia, oculogyric crisis, extra pyramidal (EPS) side effects and tardive dyskinesia.
3. Discuss the effects and severe side effects of anticholinergic drugs.
4. Develop a short teaching plan for a patient receiving anticholinergics.
5. Discuss the withdrawal and addiction potential of benzodiazepines.
6. Discuss the adverse reactions to Clozaril and interventions.
7. Discuss the dietary restrictions for MAO inhibitors.
8. List two other terms used in referring to antipsychotics.
9. Identify a positive patient outcome with antipsychotic therapy.
10. Indicate why the physician would change classes of antipsychotic drugs in the treatment of patients.
11. What is the most common EPS side effect?
12. Identify the symptoms of withdrawal from anti-anxiety medications – ie. Valium.
13. Indicate the greatest potential for drug overdose with benzodiazepines.
15. Discuss the importance of sitting and standing blood pressures and for which medication regime this is important.
16. Discuss the side effects of Prozac.
17. Identify a strategy for alleviating nasal congestion as a side effect to antipsychotics.
18. Discuss the side-effects and nursing interventions for patients receiving lithium therapy.
19. Discuss the laboratory assessment for patients started on Lithium treatment.
20. Relate the importance of assessing target symptoms.
(21) Describe tardive dyskinesia.*
(22) Describe the symptoms of neuroleptic malignant syndrome.*
(23) Indicate when patients are most likely to terminate use of their anti-psychotic drug.*
(24) Develop a teaching plan for a patient on phenothiazines.*
(25) Discuss the side effects, adverse effects, nursing interventions and therapeutic window for Lithium.*
(26) Identify the function, symptom management and adverse effects of the atypical anti-psychotics.*

Relate the significance of nursing management of the therapeutic milieu
Nurse role in evaluation of environment*
Definition of the milieu
Components of the milieu
Function of the interdisciplinary team*
Nursing management of the milieu*

WEEK # 3: Advanced therapeutic communication
Discuss observation of process*
Discuss strategies for communicating with the delusional and hallucinating patient*
List two strategies to help the patient focus on feelings.*

Anxiety
Relate critical elements of anxiety, coping and anxiety management*
Levels of anxiety*
Identify 3 nursing interventions for an anxious patient
Identify defense mechanisms and relate their function*
List six defense mechanisms and define*
Discuss two major reasons that individuals use defense mechanisms*
Define transference and counter-transference

WEEK # 4: EXAM I
Discuss the Johari Window and its relationship to confrontation and awareness both for the nurse and the patient*
WEEK #5: Managing aggression and anger
Identify strategies for managing anger and aggression*
Relate the assessment of impending aggression*
Discuss the medications prescribed for aggression*
Select important elements in restraint/seclusion*
Identify the significance of limit setting in managing anger/aggression*
Evaluate the effect of therapeutic confrontation – theoretically based – in communicating the psychiatric patient*

Crisis Intervention
Discuss the steps and nursing actions related to in crisis intervention*
Relate the types of crises that patients may experience*
Relate the concepts of crisis intervention to the nursing process
Evaluate the role of the nurse as a crisis interventionist*
Define catharsis*

WEEK #6: Psychotic disorders and schizophrenia
Define the following four types of schizophrenia: paranoid, disorganized, catatonic and undifferentiated.*
Define Type I and Type II schizophrenia.
List and define Bluelar’s 4-As of schizophrenia.
Describe why reality therapy is important in schizophrenia.*
Identify two strategies for communicating with the delusional and hallucinating patient.*
Discuss the therapeutic interventions for schizophrenic patient.*
Identify the therapeutic role of the nurse caring for the psychotic patient.*

Violence in a Psychiatric Hospital
Identify interventions related to violence in the psychiatric hospital*
Relate the importance of critical incident management*
Discuss the diagnoses of client’s at high risk for violence in a psychiatric hospitals*

WEEK #7: Mood Disorders: Depression, Bi-polar disorder and suicide
Identify two medications commonly used in the treatment of depression.*
Discuss the types of depression.*
Discuss the nursing interventions for depressed patients.*
Identify the nutritional concerns for the depressed patient.*
Discuss why activities are important for the depressed patient.*
Define bi-polar disease.
Discuss the communication and limit setting strategies used with the manic patient.*
List four nursing interventions critical for the manic patient.*
Develop a drug teaching plan for the patient on Lithium.*
Suicide and suicidal ideation; indirect self-destructive behavior, ECT, crisis hotline.*
Relate the significance of the cognitive-behavioral interventions.*

WEEK #8: EXAM II
**Personality Disorders**
Identify the various personality disorders, the clusters and their effect on the patient’s functioning.*
List four interventions for the following personality disorders:
Anti-social*
Borderline*
Obsessive-Compulsive disorder*
Identify the phobic disorders and their effect on patient functioning.
Discuss the symptoms of dissociative disorders

WEEK #9: **Substance abuse disorders**
Define nursing assessment strategies for the patient who is detoxifying from alcohol.*
Discuss why antabuse is used with alcoholics.*
Identify the patient teaching related to antabuse use.*
Define the Preferred Defensive Structure of the addictive patient.
List four critical nursing interventions for the patient withdrawing from alcohol.*
Describe the neurochemistry of addiction
Discuss relapse prevention strategies.*
Identify the effects of amphetamine abuse.*
Define two metabolic interventions for drug craving

**Eating disorders**
List common symptoms of bulimia.*
Discuss interventions for the bulimic patient*
Identify nursing interventions for the anorectic patient.*

WEEK # 10: Domestic violence
Discuss the elements related to domestic violence.*
Discuss human responses to trauma
Identify the constellation of behaviors related to battering and abuse
Identify the crisis intervention strategies related to domestic violence.*
Relate the treatment focus of domestic violence to partner and child abuse
Discuss the critical issues related to domestic violence and the role of the nurse

Child
List three critical elements in the psychiatric care of the child
Discuss the purpose of play therapy.
Describe the care of the autistic child.
Relate important interventions for the ADD/ADHD child.

Adolescent
List three critical elements in the psychiatric care of the adolescent

WEEK #11: EXAM III: *Child & Adolescent NOT tested on EXAM III
Elder and Families
Discuss the psychiatric issues critical to the elderly.
Discuss the importance of family therapy.

WEEK #12: Exam III – Statistical Review
Famous Persons Presentations

WEEK # 13: Famous Persons Presentations

WEEK #14: Famous Persons Presentations

WEEK #15: HESI EXIT EXAM TBA
On a Wednesday morning in 2008 in Lewisville, Ohio, a man walked into Samuels Hardware Store, grabbed an pick-ax, and began swinging at the customers and shouting about the devil. When he left, one person was dead and two others were critically injured. Ten days later, police received a call from Mr. T., who was a patient in the 49-bed psychiatric unit at St. John’s Hospital. Mr. T told the police that his roommate at the hospital confessed to the crime in Lewisville. However, he didn’t know his roommate’s name but they could get it from the nurses. The police contacted Nurse S. and asked her to identify the patient but she refused to do so. She told them that she believed his name was shielded by state mental health law guaranteeing the confidentiality of mental patients. Hospital administrators supported her decision and obtained legal counsel for her.

QUESTIONS:

1. Why did the nurse require legal counsel?

2. Was the nurse legally correct in her refusal to divulge information? Why?

3. Was the nurse ethically correct in her refusal to divulge information? Why?

4. If she had divulged the identity of the patient, what legal action could be taken against her, if any?

5. Under what circumstances could the nurse be required to divulge information about this case?

Be prepared to discuss this case in class.
LEGAL/ETHICAL
CLINICAL CASE: #2

Thomas W., age 30, was brought to the hospital by city police. He was found outside the city library ranting and raving about Satan. He was admitted to the unit with a diagnosis of schizophrenia, paranoid type. He told the nurse that he has electricity in his blood and that he possessed super powers given to him by God. Although he was not displaying weapons at the time of the arrest, the police found and confiscated a gun from Mr. W. During a conversation with the nurse on the third day after admission, he tells her that his ex-girlfriend works at the city library and that he was going there to kill her because she is filled with Satan. He becomes very secretive and suspicious when the nurse asks him if he still wants to kill his girlfriend. At one point he looks at the nurse with a murderous look in his eyes and says: "You are just like her! The Holy Ghost told me you are filled with Satan, too!!"

QUESTIONS:

1. What is the best action for the nurse to take at this moment?

2. Does the nurse report the patient's intent to kill his girlfriend? If so, why?

3. To whom does the nurse report the intent?

4. What will happen to the nurse if she:

   Does report the intent?

   Does not report the intent?

5. What is likely to happen to Mr. W?

Be prepared to discuss in class.
LEGAL/ETHICAL  
CLINICAL CASE: # 3

Carrie Williams has been admitted to the Psychiatric Unit at Bayshores Treatment Facility. She is eight-and-one-half months pregnant and in a manic state. She has not slept for three days, is hyperactive and hypervoluble. When you come on duty, she is running all over the Day Room, jumping from chairs and standing on tables saying to everyone: "I am Cicely Tyson and I will perform for you. My agent wants you to listen to me and come to see my movies. I'm going to Hollywood and if you treat me right I will take you along."

Along with several other nurses, you decide the patient must be placed in seclusion for her protection and the safety of the fetus. Also, she is disrupting the Unit and upsetting the other patients. Tension in the Day Room is very high as Mrs. Williams climbs over the back of a sofa and almost falls over a table.

After being placed in seclusion, the patient rolls on the floor and bounces herself off the walls with her protruding stomach. The psychiatrist is notified and orders that liquid Haldol (an appropriate dosage for the patient) be injected into the patient's sealed juice containers and that she be encouraged to drink the juice. As the nurse working with this patient you would:

QUESTIONS:

1. Call the Patient's Rights Advocate since this patient's mental health rights are being violated.

2. Inject the Haldol into the patient's juice and encourage her to drink it.
3. Refuse to administer the medication to the patient.

4. Tell the physician if he wants the medication injected into the patient's juice without her knowledge - he can do it.

Be prepared to discuss in class.
APPENDIX B

ETHICAL CONCEPTS

1. AUTONOMY - The right of self-determination, independence and freedom.

2. JUSTICE - The obligation to be fair to all people.

3. FIDELITY - The person’s obligation to be faithful to commitments made to the self and others.

4. BENEFICENCE - The commitment to do only that which is good for the patient.

5. NONMALEFICENCE - The requirement that health care providers do no harm to patients.

6. VERACITY - The requirement that the health provider tell the truth and not intentionally deceive.

7. STANDARD OF BEST INTEREST - A decision that is made about the person’s health care when they are unable to make an informed decision.

8. RIGHTS - Claims or titles; something that is owed to in order to fulfill just claims.

9. UTILITARIANISM - The ethical system of utility; greatest good for the greatest number and the end justifies the means.

10. DEONTOLOGY - A system of ethical decisions based on moral rules and unchanging principles.
APPENDIX C

Examination Blue Prints
I, II, III

TEST CHALLENGE FORMS

Examination: I, II, III
### Exam I Blueprint

<table>
<thead>
<tr>
<th>Textbook Chapters</th>
<th>Topic/s</th>
<th>Number of Questions</th>
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<tbody>
<tr>
<td>3, 5, 13</td>
<td>Legal Ethical Therapeutic Interventions (Communication) Conceptual Models</td>
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<tr>
<td>7, 11, 32</td>
<td>Psychopharmacology Nursing Assessment Therapeutic Milieu</td>
<td>18</td>
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<td>3</td>
</tr>
<tr>
<td>8, 29, 30</td>
<td>Anxiety Defense Mechanisms</td>
<td>15</td>
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### Exam II Blueprint

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<td>34, 35</td>
<td>Anger/Aggression &amp; Restraint/Seclusion Crisis Intervention</td>
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<td></td>
<td>14</td>
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<tr>
<td>16, 30</td>
<td>Psychopathology – Psychoses and Schizophrenia Violence in a Psychiatric Setting</td>
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<td></td>
<td>6</td>
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<td>Substance Abuse/Detoxification</td>
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<td>17, 18, 22, 23, 31</td>
<td>Mood Disorder</td>
<td>15</td>
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<td>Suicide</td>
<td>12</td>
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<tr>
<td></td>
<td>Personality Disorders</td>
<td>14</td>
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<tr>
<td>21 &amp; 24</td>
<td>Eating Disorders</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Domestic Violence</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
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CRITERIA – GROUP POWER POINT PRESENTATION
MENTAL ILLNESS AND FAMOUS PERSONS

**Group Assignment** (Approximate time 30 minutes)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Points</th>
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<tr>
<td>1. Select a famous person – living or dead to assess for mental illness – describe the demographics and behaviors of that person.</td>
<td>10</td>
</tr>
<tr>
<td>2. Using the mental status exam or brief psychiatric scale* – evaluate that persons mental status with available pertinent information from the literature (use only areas that apply).</td>
<td>20</td>
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<tr>
<td>3. Determine a DSM-IV diagnosis for that person (Text</td>
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</table>
Appendix A).

4. Determine two nursing diagnoses pertinent for this person’s mental status and nursing care needs.

5. Identify five nursing interventions for each nursing diagnosis. Include rationale for each intervention.

6. Prepare a PowerPoint presentation addressing these criteria and present this information during the assigned class period. Time: 30-35 minutes  Peer evaluation.

7. APA (possible 7 pts) and grammar (possible 8 pts)

* See your syllabus

**Group members**

____________________  ____________________

____________________  ____________________

____________________  ____________________

____________________  ____________________

APPENDIX D

BRIEF PSYCHIATRIC ASSESSMENT

**ANXIETY**

Demonstrates excessive worry, fear, over-concern for the present or future.

**PHYSICAL CONCERNS**
Preoccupation with physical health, fear of physical illness, talks incessantly about ailments.

**EMOTIONAL WITHDRAWAL**

Lack of spontaneous interaction, isolation, deficiency in relating to others.

**DISRUPTIONS IN THOUGHT**

Thought processes are confused, disconnected, disorganized, grandiose or obsessive.

**GUILT FEELINGS**

Extreme self-blame, shame and remorse over the past or behavior. Inability to shift focus of topic from shame and blame.

**TENSION**

Physical and motor evidence of nervousness, over-activation.

**MANNERISMS AND POSTURING**

Peculiar physical movements, bizarre and unnatural motor behavior.

**GRADIOSITY**

Exaggerated self-opinion, arrogance, conviction of super-human or unnatural powers of abilities.

**DEPRESSIVE MOOD**

Extreme sadness, despondency, pessimism and sorrow. Unable to energize; moves in slow-motion, sits or sleeps a lot.

**HOSTILITY**

Animosity, contempt, belligerence and disdain for others. Assumes aggressive stances and using threatening body movements.

**SUSPICIOUSNESS**

Mistrust, belief that others harbor malicious or discriminatory intent. Guarded and watchful.
HALUCINATIONS

Grinning, laughing, moving lips without making any sounds, slowed verbal responses as if preoccupied. Silent, sits by self. Suspicious of questions. Reports threatening and accusatory voices. Voices may instruct to hurt self or others.

MOTOR RETARDATION

Slowed, weakened body movements or speech. Sluggish in walking. Frequent sighs and preference for sitting or lying down.

UNCOOPERATIVENESS

Resistance, guardedness, rejection or suspicion of authority.

UNUSUAL THOUGHTS

Reports unusual, odd, strange, bizarre thought content.

BLUNTED EXPRESSIONS

Reduced emotional tone, agitation, increased reactivity.

DIORIENTATION

Confusion or lack of proper association to time, person or place.

EXCITEMENT

Heightened emotional tone, agitation, increased reactivity.

SUICIDAL IDEATIONS

Expresses thoughts of self-harm; identifies a plan, method and means.

Medication Facts

Lithium
- Is completely absorbed in 6 hours after oral administration
- Steady lithium level achieved in 4-7 days
- 95% of lithium is excreted by the kidneys
- AM blood draws are taken BEFORE the morning Lithium is administered
- **Laboratory Tests prior to and during treatment**
  - Serum Creatinine – if increases during treatment obtain creatinine clearance – decreased creatinine clearance obtain renal consult

Risperidone (Risperdal)
- This class of drugs decreases hallucinations by affecting the dopamine level in the brain
- Has fewer EPS side effects because it targets specific dopamine receptors

Anticholinergic Drugs: Benztropine (Cogentin) and trihexyphenidyl (Artane)
- This class of drugs is used to treat EPS in patients on typical/first generation anti-psychotics
- Nurse monitors for a reduction in rigidity after treatment with these drugs for EPS
- Anticholinergic drugs may impair memory and learning

Monoamine Oxidase Inhibitors (MAOIs)
- This class of anti-depressants requires monitoring and health teaching to prevent a hypertensive crisis. Health teaching focuses on avoiding tyramine containing foods.
- Trade names for these drugs are Parnate, Nardil and Marplan

Benzodiazepines (Valium, Xanax, Librium, Ativan)
- Critical issues are that the client should not abruptly terminate their use but should be tapered off to avoid withdrawal symptoms
- These medications cannot be used in conjunction with alcohol or other CNS depressants
- Medications in this class must be monitored closely as they are addictive
- Patient will feel sleepy initially until tolerance builds
- Lorazepam (Ativan) given for agitation: the nurse assesses for reduced signs of agitation such as hyper-vigilance
SSRIs (Prozac, Zoloft, Paxil, Celexa)

- Often cause GI distress such as nausea; they should be taken with meals

**EPS with highest priority of intervention**

- Dysphagia – difficulty breathing, swallowing – medicate with Cogentin immediately
- Tardive Dyskinesia (TD) – monitor by means of the AIMS and inform health care provider of AIMS result if indicative of TD

**Nursing actions in monitoring psychotropic drugs**

- Monitor for EPS and medicate PRN
- Monitor for side effects and adverse reactions
- Evaluate using the AIMS
- During the stabilization phase the nurse should assess the patient for target symptoms and side effects
- In chronic patients, assessments of past or current compliance with medication is important

**Clozapine (Clozaril)**

- Monitor for agranulocytosis which may manifest as flu like symptoms

**Administration of antacids**

- If the patient is on a phenothiazine drug (such as Thorazine) – administer antacid 1 hour before the phenothiazine

### Medication Side-Effects and Alleviation Methods

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Dry mouth</td>
<td>• Sugarless chewing gum</td>
</tr>
<tr>
<td></td>
<td>• Sugarless hard candy or mints</td>
</tr>
<tr>
<td></td>
<td>• Citrus naturally sweetened juices</td>
</tr>
<tr>
<td></td>
<td>• Water with lemon or lime juice</td>
</tr>
<tr>
<td>Dry eyes</td>
<td>• Natural tears eye drops</td>
</tr>
<tr>
<td></td>
<td>• Cool pack over closed eyes frequently</td>
</tr>
</tbody>
</table>
| Sensitivity to sun light                  | • Sun glasses  
• Sun block  
• Wide brimmed hat  
• Clothing that covers the skin |
|-----------------------------------------|--------------------------------------------------|
| Constipation                            | • Increase fluid intake – water and unsweetened juices  
• Increase fiber rich foods – whole grains, fruits with skins, vegetables with skins  
• Increase exercise |
| Nasal congestion                        | • Saline nose spray  
• Increased exposure to hydrated air – shower, sink with running water |
| Weakness, fatigue, dizziness when standing up from sitting or lying down | • Change positions gradually and in stages – sit first then stand slowly  
• Rise from sitting to standing slowly  
• Maintain adequate salt, fluid intake |
| Memory impairment                       | • Read or study in small sections  
• Review elements for retention frequently  
• Verbally report what is to be remembered  
• Repeat verbalizations often |
| Increased appetite                      | • Eat foods that require a lot of chewing such as fruits and vegetables with skins  
• Supplement between meals with water or naturally sweetened juices  
• Chew sugarless gum |
| Decrease appetite                       | • Consume high energy producing foods such as fish, poultry and lean beef  
• Eat foods rich in nutrients such as fruits and vegetables  
• Supplement high protein meals with pasta, grains and brown rice |
| Mild restlessness                       | • Exercise; take short fast walks; stretch the muscles; relax to music |


## Contact Health Care Provider

<table>
<thead>
<tr>
<th>Contact Your Health Care Provider</th>
<th>Symptoms</th>
</tr>
</thead>
</table>
| If you have the following symptoms contact your health care provider immediately | • Eye pain  
• Blurred vision  
• Rapid heart beat  
• Abnormal heart beat – such as |
skipping

- Inner restlessness/fidgeting – unable to be still
- Jerking muscles – not under conscious control
- Inability to urinate
- Severe pain in intestines
- Pain in calves of legs
- Weight gain
- Excessive thirst and urination
- Tightness in throat, tongue, jaw, neck
- Eyes locked upward
- Twisting or stiffness of neck
- Elevated temperature
- Mouth sores
- Swollen glands in the neck – sore throat
- Flu-like symptoms
- Seizure
- Menstrual irregularities
- Breast enlargement


### Strategies for Coping with Persistent Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Hallucinations</td>
<td>- Hum or sing&lt;br&gt;- Take a nap&lt;br&gt;- Tell the voices to go away&lt;br&gt;- Demand that the voices go away&lt;br&gt;- Think “STOP”&lt;br&gt;- Talk with friends/family&lt;br&gt;- Go to a movie&lt;br&gt;- Read a book, magazine or newspaper&lt;br&gt;- Debate with voices&lt;br&gt;- Do physical exercise&lt;br&gt;- Watch TV&lt;br&gt;- Do your favorite hobby&lt;br&gt;- Listen to the radio&lt;br&gt;- Sew, crochet, carve – something fine motor&lt;br&gt;- Do cross-word puzzle or video game</td>
</tr>
</tbody>
</table>
Other Hallucinatory Experiences (Visions)  
- Do your favorite hobby  
- Lie down and relax  
- Think “STOP”  
- Watch TV  
- Read a book, newspaper, magazine  
- Do physical exercise  
- Talk with friends  
- Listen to the radio  
- Go to a movie  
- Play a video game or cross-word puzzle

Delusions (Bad or unusual thoughts or feelings)  
- Lie down and relax  
- Talk with friends  
- Do your favorite hobby  
- Take a nap  
- Read a book, newspaper or magazine  
- Do physical exercise  
- Think “STOP”  
- Watch TV  
- Play a video game

Depression (Bad mood, sadness)  
- Do physical exercise  
- Talk with friends  
- Go to a movie  
- Read a book, newspaper or magazine  
- Watch cartoons  
- Write a letter

Anxiety  
- Do physical exercise  
- Talk with friends  
- Go to a movie  
- Play a video game

<table>
<thead>
<tr>
<th>Defense Mechanism</th>
<th>Definition</th>
<th>Example</th>
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</thead>
<tbody>
<tr>
<td>Acting out</td>
<td>Using actions rather than reflections or feelings during periods of emotional conflict</td>
<td>A teenager gets mad at parents and begins staying out late at night.</td>
</tr>
<tr>
<td>Affiliation</td>
<td>Turning to others for help or support (sharing problems with others without implying that someone else is responsible for them)</td>
<td>An individual has a fight with spouse and turns to best friend for emotional support.</td>
</tr>
<tr>
<td>Altruism</td>
<td>Dedicating life to meeting the needs of others (receives gratification either vicariously or from the response of others)</td>
<td>After being rejected by boyfriend, a young girl joins the Peace Corps.</td>
</tr>
<tr>
<td>Anticipation</td>
<td>Experiencing emotional</td>
<td>A parent cries for 3 weeks</td>
</tr>
<tr>
<td>Reactions in advance or anticipating consequences of possible future events and considering realistic, alternative responses or solutions.</td>
<td>Before the last child leaves for college. On the day of the separation, the parent spends the day with friends.</td>
<td></td>
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</tr>
<tr>
<td>Autistic fantasy</td>
<td>Excessive daydreaming as a substitute for human relationships, more effective action, or problem solving.</td>
<td>A young man sits in his room all day and dreams about being a rock star instead of attending a baseball game with a friend.</td>
</tr>
<tr>
<td>Circumstantiality</td>
<td>Bringing up details that are irrelevant to the discussion at hand.</td>
<td>A woman is talking about her husband and brings in detailed information about his sister.</td>
</tr>
<tr>
<td>Compensation</td>
<td>Attempting to compensate for ego deficit</td>
<td>A man brags about his high IQ though he has numerous problematic relationships.</td>
</tr>
<tr>
<td>Confabulation</td>
<td>Filling in memory gaps with untrue/unsubstantiated events.</td>
<td>An elderly woman talks about the visit of her daughter from out-of-town who has not visited in weeks.</td>
</tr>
<tr>
<td>Conversion</td>
<td>Converting anxiety into a physiological event</td>
<td>Clients request headache and anti-acid medications after group.</td>
</tr>
<tr>
<td>Denial</td>
<td>Refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others (psychotic denial used when there is gross impairment in reality testing)</td>
<td>A teenager’s best friend moves away, but the adolescent says he does not feel sad.</td>
</tr>
<tr>
<td>Devaluation</td>
<td>Attributing exaggerated negative qualities to self or others.</td>
<td>A boy has been rejected by his long time girlfriend. He tells his friends that he realizes that she is stupid and ugly.</td>
</tr>
<tr>
<td>Displacement</td>
<td>Transferring a feeling about, or a response to, one object onto another (usually less threatening), substitute object.</td>
<td>A child is mad at her mother for leaving for the day, but says she is really mad at the sitter for serving her food she does not like.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Experiencing a breakdown in the usually integrated functions of consciousness, memory, perception of self or the environment, or sensory and motor behavior.</td>
<td>An adult relates severe sexual abuse experienced as a child, but does it without feeling. She says that the experience was as if she were outside her body watching the abuse.</td>
</tr>
<tr>
<td>Help-rejecting complaining</td>
<td>Complaining or making repetitious requests for help that disguise covert feelings of hostility or reproach toward others, which are then expressed by rejecting the suggestions, advise, or help that others offer (complaints or requests may involve physical or psychological symptoms or life problems).</td>
<td>A college student asks a teacher for help after receiving a bad grade on a test. Every suggestion the teacher has is rejected by the student.</td>
</tr>
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</tr>
<tr>
<td>Humor</td>
<td>Emphasizing the amusing or ironic aspects of the conflict or stressor.</td>
<td>A person makes a joke right after experiencing an embarrassing situation.</td>
</tr>
<tr>
<td>Idealization</td>
<td>Attributing exaggerated positive qualities to others</td>
<td>An adult falls in love and fails to see the negative qualities in the other person.</td>
</tr>
<tr>
<td>Intellectualization</td>
<td>Excessive use of abstract thinking or the making of generalizations to control or minimize disturbing feelings.</td>
<td>After rejection in a love relationship, the rejected explains about the relationship dynamics to a friend.</td>
</tr>
<tr>
<td>Isolation of affect</td>
<td>Separation of ideas from the feelings originally associated with them</td>
<td>The individual loses touch with the feelings associated with a rape while remaining aware of the details.</td>
</tr>
<tr>
<td>Omnipotence</td>
<td>Feeling or acting as if one possesses special powers or abilities and is superior to others.</td>
<td>An individual tells a friend about personal expertise in the stock market and the ability to predict the best stocks.</td>
</tr>
<tr>
<td>Passive aggression</td>
<td>Indirectly and unassertively expressing aggression toward others. There is a façade of overt compliance masking covert resistance, resentment, or hostility</td>
<td>Passive aggression often occurs in response to demands for independent action or performance or the lack of gratification of dependent wishes but may be adaptive for individuals in subordinate positions who have no other way to express assertiveness more overtly.</td>
</tr>
<tr>
<td>Projection</td>
<td>Falsely attributing to another one’s own unacceptable feelings, impulses, or thoughts.</td>
<td>A child is very angry at a parent, but accuses the parent of being angry.</td>
</tr>
<tr>
<td>Concept</td>
<td>Definition</td>
<td>Example</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Projective</td>
<td>Falsely attributing to another one’s own unacceptable feelings, impulses, or thoughts. Unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affect or impulses but misattributes them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.</td>
<td>A child is mad at a parent, who in turn becomes angry with the child, but may be unsure of why. The child then feels justified at being angry with the parent.</td>
</tr>
<tr>
<td>Rationalization</td>
<td>Concealing the true motivations for one’s own thoughts, actions or feelings through the elaboration of reassuring or self-serving but incorrect explanations.</td>
<td>A man is rejected by his girlfriend, but explains to his friends that her leaving was best because she was beneath him socially and would not be liked by his family.</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>Substituting behavior, thoughts, or feelings that are diametrically opposed to one’s own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression)</td>
<td>A wife finds out about her husband’s extramarital affairs and tells her friends that she thinks his affairs are perfectly appropriate. She truly does not feel, on a conscious level, any anger or hurt.</td>
</tr>
<tr>
<td>Repression</td>
<td>Expelling disturbing wishes, thoughts, or experiences from conscious awareness (the feeling component may remain conscious, detached from its associated ideas).</td>
<td>A woman does not remember the experience of being raped in the basement, but does feel anxious when going into that house.</td>
</tr>
<tr>
<td>Self-assertion</td>
<td>Expressing feelings and thoughts directly in a way that is not coercive or manipulative.</td>
<td>An individual reaffirms to another that going to a ball game is not what he or she wants to do.</td>
</tr>
<tr>
<td>Self-observation</td>
<td>Reflecting feelings, thoughts, motivation and behavior and responding to them appropriately.</td>
<td>An individual notices an irritation at his friend’s late arrival and decides to tell the friend of the irritation.</td>
</tr>
<tr>
<td>Splitting</td>
<td>Compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images.</td>
<td>Self and object images tend to alternate between polar opposites: exclusively bad, hateful, angry, destructive, rejecting, or worthless. Once friend is wonderful and another former friend, who was at one time viewed as being perfect, is now believed to be an evil person.</td>
</tr>
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</tr>
<tr>
<td>Sublimation</td>
<td>Channeling potentially maladaptive feelings or impulses into socially acceptable behavior.</td>
<td>An adolescent boy is very angry with his parents. On the football field, he tackles someone very forcefully.</td>
</tr>
<tr>
<td>Suppression</td>
<td>Intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences.</td>
<td>A student is anxiously waiting for tests results, but goes to a movie to stop thinking about it.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Words or behavior designed to negate or to make amends symbolically for unacceptable thoughts, feelings, or actions.</td>
<td>A man has sexual fantasies about his wife’s sister. He takes his wife away for a romantic weekend.</td>
</tr>
</tbody>
</table>

APPENDIX E

POWER POINT OUTLINES

LECTURE WEEK # 1

TEXAS MENTAL HEALTH CODE
   Judith A. Sutherland, Ph.D., R.N., CNS, L.C.D.C.
   Adopted by Carmen Hernandez MSN, RN

LEGAL ISSUES
COURSE OVERVIEW
   • Texas Mental Health Code
   • Voluntary/Involuntary Commitment
   • Commitment of a minor
   • Definitions of Legal Status
   • Patient’s Rights
   • Civil Suits
   • Criminal Charges
TEXAS MENTAL HEALTH CODE

• State law that governs the commitment and treatment of psychiatric patients in the State of Texas
• Nurses who fail to follow The State statutes are liable for State prosecution and risk civil court actions such as mal-practice, criminal charges and criminal lawsuits

ETHICS

• Nurses are bound by the nurse practice act and code of ethics to follow State statutes
• Psychiatric patient’s rights are dependent upon The Texas State Mental Health Code
• Nurses are held liable for ANY violation of The Mental Health Code
• The nurse must carefully balance patient status against elements of The Code

DEFINITIONS OF LEGAL STATUS

• Voluntary - form signed by patient who agrees to voluntary treatment
• Admission of Minors - a patient sixteen (16) years of age and over can request admission and dismissal without parental consent

• A minor in Texas is 15 years and under
• Magistrate Warrant - issued by local Magistrates

DEFINITIONS

• Magistrate’s warrant - patients are brought in for treatment by Mental Health Deputies; evaluated by a physician and the warrant is converted to ORDER OF PROTECTIVE CUSTODY (OPC); VOLUNTARY ADMISSION OR PATIENT IS DISCHARGED
• Certificate of Medical Examination for mental illness - required on all Warrants and application for detentions to form ORDER OF PROTECTIVE CUSTODY (OPC). It is a form signed by physician which states patient meets criteria for Court Ordered Mental Health Services
• Commitment - Ordered by the JUDGE after the case is presented in Court. Patient can be committed to County Facility, VA, State hospital OR if has insurance a private psychiatric hospital
• Court Order (C/O) - Ordered by a JUDGE after a case is presented in Court

COMMITMENT PROCEEDINGS

• MENTAL HEALTH WARRANT
• MEDICAL EXAMINATION

• MENTAL HEALTH COURT - JUDGE

• RELEASED

• OPC-HOSPITALIZED

• EMERGENCY - 3 TO 30 DAYS

• TEMPORARY - 2 TO 6 MONTHS

• INDEFINITE – GUARDIAN

– Family/Friend or State Appointed

Criteria for Order of Protective Custody

• Danger to self

• Danger to others

• Gravely disabled

• All, two or one

VOLUNTARY STATUS

• Patient may check out of hospital at any time

• If physician and staff determine patient needs to stay a 96 hour letter is initiated to begin commitment (OPC) hearings

• Physician can petition for OPC for patient who is in need of involuntary treatment
PATIENT’S RIGHTS
- Right to appropriate treatment supportive of a person’s personal liberty
- Right to individualized, written treatment plan and its periodic review and assessment
- Right to freedom from restraint or seclusion
- Right to access telephone, mail and visitors
- Right not to receive treatment except in emergency situation

CIVIL LITIGATIONS AND TREATMENT
- False imprisonment
- Assault
- Battery
- Assault and Battery
- Malicious prosecution
- Negligence

SECLUSION
- Placing the patient in a locked room where freedom is denied
- May be placed in room by R.N.; phone order obtained immediately, signed/seen by physician within 2 hours and re-ordered by physician every 4 hours
- Patient monitored continuously, ADL’s given every two hours, evaluated

RESTRAINT
- Leather restraints either in seclusion or not in seclusion
- May be placed by R.N., phone order obtained immediately, signed/seen by physician within 2 hours, and re-ordered every 4 hours, or depending on the age of client.
- Patient monitored continuously and provided ADLs every 2 hours

ETHICAL CONSIDERATIONS
- Duty to Disclose
- Involuntary patient given liquid medication in grape juice without knowledge
- Involuntary patient given IM medication despite refusal
- Medication withheld until patient goes to Court to see Judge
- Ward phones shut off to prevent calls at certain times
- Visitors denied at certain times
- Administrative discharges based on behaviors
• Placement of patient in restraint or seclusion
• Not intervening in dangerous behavior of patient on the unit

**NURSING ROLE**

• Maintain respect and empathy for the plight and suffering of the mentally ill
• Set consistent, firm and clear limits with respect for patient rights
• Follow strict policies when Patient Rights must be amended due to psychotic behavior
• Re-institute rights when patient able to cope

**Critical Thinking Question 1**

• A chronic schizophrenic male seen by the mental health nurse in the community for administration of Prolixin decanoate refuses his medication at one regularly scheduled visit. What is the appropriate action by the nurse?

**Critical Thinking Question 1**

• A. Tell him he has the right to refuse
• B. Tell him if he does not take his medication he will have to be hospitalized
• C. Talk with a family member about adding medication to the patient’s morning orange juice.
• D. Call for Security to help give the injection to the patient.

**Critical Thinking Question 2**

• In an effort to implement the least restrictive principle and implement an alternative to leather restraints, the nurse would:
• A. Place the patient in a locked room
• B. Place the patient in soft, Posey restraints, rather than leather
• C. Provide the PRN ordered medication for agitation
• D. Tell the patient if he doesn’t calm down he will have to have ECT

**Critical Points from Text**

• Guilty but Mentally Ill pg. 272
• Competency to Stand Trial pg. 272 Conviction of incompetent person is violation of the 14th Amendment – will be remanded for treatment
• Psychiatric Advanced Directive pg. 275
• Right to informed consent pg. 276

Conceptual Models - Psychiatric Treatment

Psychoanalytical Model

- Id
- Ego
- Super-ego
- Ego defense mechanisms
- Freud, Jung, Erikson, Horney, Fromm-Reichmann, Menninger

**Critical Thinking Questions**
- *Is this model still used in treatment?*
- *What kind of patients benefit from this type of therapy?*
- *What did this model contribute to understanding about mental illness?*

Interpersonal Model

- Reduce symptoms
- Improve social functioning
- Develop adaptive behaviors
- Harry Stack Sullivan, Hildegard Peplau

**Critical Thinking Questions**
- *What type of patients benefit from this model of therapy?*
- *Who uses this form of therapy?*
- *What relationship does this therapy have to inpatient treatment?*

Supportive Therapy Model

- Promote supportive relationship between patient and therapist
- Enhance patient strengths, coping skills, and coping resources
- Reduce distress and maladaptive behaviors
- Promote independence - a much as possible
- Foster autonomy in decision making

**Critical Thinking Questions**
- *With what kind of patients is this therapy effective?*
- *Who uses this form of therapy?*
- *What relationship does this therapy have to inpatient treatment?*
Existential Model

- RET - ABC
- Logo Therapy
- Reality Therapy
- Gestalt Therapy
- Encounter Therapy

Critical Thinking Questions

- Would nurses use this form of therapy?
- What kind of patients might benefit from this type of therapy?

Medical Model

- Medical Diagnosis
- Somatic Treatments - ECT, Pharmacotherapy, Psychoanalysis

Psychiatric Nurse Role and Therapeutic Interventions

Psychiatric Nurse Role

- Advocacy
- Contract for Care
- Observation of Process
- Empathy
- Self-Disclosure
- Self-Awareness

Specific Psychiatric Interventions

- Reality orientation
- Re-directing
- Deflecting to the feelings
- Limit setting
- Behavior modification techniques
- Encouraging ventilation
- Problem-solving

Reality Orientation

- “I know that is real to you but it is not real to me.”
- “I do not hear any voices.”
“I do not believe the CIA are listening to us.”
“Do not have a microphone on my name tag.”
“You can make a decision to change your behavior - it is within your control.”
“Your life will change when you make a decision to change it.”

**REDIRECTING**
“Let’s go for a walk and talk.”
“I know you are angry right now - let’s talk about what you can do about the anger.”
“If you look at me and talk to me it is likely the voices will go away or diminish.”
“Let’s identify some things you can do with those angry feelings.”

**DEFLECTING TO FEELINGS (good opening comments/questions)**
The patient is verbally attacking you: “You seem really angry - tell me what this is about.”
“I see you walking very rapidly around the Day Room - what’s going on with you right now?”
“You seem anxious - tell me what’s going on right now.”
“There’s something else going on - what is it?”

**LIMIT SETTING**
“I know you are upset however you cannot talk to me that way.”
“That behavior (describe) is not appropriate.”
“If you cannot control your behavior we need to look at some ways to help you control it.”
“Let’s start with one problem/issue at a time.”
“You may not touch me.”
“Let’s try to focus on the issue.”
“Come and tell me when you are feeling very angry and we will: Go for a walk, talk about it, go to the weight room.”
“Let’s talk about what you can do instead of yelling in the Day Room.”
“I’d rather talk about you than me.”

**BEHAVIOR MODIFICATION TECHNIQUES**
Positive reinforcement
Extinguish the behavior
◆ Negative reinforcement
◆ Modeling
◆ Contracting

ENCOURAGING VENTILATION
◆ Release phenomenon
◆ Fosters reality testing
◆ Eliminates perceptual distortions
◆ Reduces self-referencing
◆ Provides opportunity to confront defense mechanisms
◆ Prevents sand-bagging feelings

PROBLEM SOLVING
◆ Assess the events/issue/situation
◆ Identify the issue or problem
◆ Discuss relevant factors
◆ List and evaluate interventions/solutions
◆ Attempt one or more interventions
◆ Re-evaluate
◆ What to do if you get: “Yes but . . . . .“

REFRAMING
◆ Taking a seemingly negative situation or characteristic and reconstructing it in a positive manner such as with: deliberate cognition, visual imagery, affirmations

GROUP THERAPY
◆ Didactic group therapy
  ◆ A form of group therapy focused on an educational topic
◆ Process group therapy
  ◆ A form of group therapy where particular issues are processed
◆ Psychotherapy
  ◆ More long term therapy focused on personality change
◆ Psychodrama (role-playing)
  ◆ A form of therapy where conflicts are reenacted

PURPOSES OF GROUP THERAPY
◆ Information giving
◆ Information seeking
◆ Clarifying
◆ Elaborating
◆ Coordinating
◆ Instilling hope
◆ Altruism
◆ Family reenactment
◆ Guidance
◆ Identification
◆ Vicarious learning

**ROLE OF THERAPIST**

◆ Therapist is facilitator who initiates the opening phase, maintaining and building phases of the group
◆ Overall goal is to create, support and build cohesiveness so that the TREMENDOUS power within the group can be released to promote change and growth

**MILIEU THERAPY**

◆ A method of constructing the therapeutic milieu so that every interaction is growth promoting
◆ Staff-patient interactions are focused on rehabilitation of the patient

**SUMMARY**

◆ Communicating with mentally and emotionally troubled people is a skill developed over time and involves the application of the techniques discussed and theories of mental illness.

**LECTURE WEEK # 2**

**ANTI-PSYCHOTIC DRUGS**

**Presentation Objectives: Drugs used in**

◆ Schizophrenia and other Psychoses
◆ Mood Disorders
◆ Anxiety Disorders
◆ Acute Psychoses
◆ Extrapyramidal Side Effects
◆ ECT

**Terms for Anti-Psychotics**

◆ Ataractics

◆ Neuroleptics

◆ Anti-psychotics
Anti-psychotic Drugs

- Block dopamine receptors - less is available in the basal ganglia
- Hi-potency
- Lo-potency
- Cause EPS - extrapyramidal means outside of the voluntary system due to block of dopamine

Anti-Psychotic Drug Affects

- Anti-psychotics produce numerous side effects due to peripheral nervous system (PNS) effects and their central nervous system effects (CNS)
- The neurotransmitter in the cholinergic system is ACh (acetylcholine).
- ACh is found in the peripheral nervous system (PNS) at the myoneural junction of skeletal muscle, in autonomic ganglia and at parasympathetic synapses

Anti-Psychotic Drug Affects

- PNS side effects are caused by anticholinergic (against acetyl-choline) and antiadrenergic blockade.
  - Block of several cranial and other parasympathetic nerves, ie: Dry mouth - block of CN VII and IX; blurred vision and photophobia - block of CN III
  - PNS side effects are more likely to be caused by low-potency drugs such as chlorpromazine (Thorazine)
  - EPS side effects by high-potency drugs such as haloperidol
  - Antiadrenergic effects - antagonism of noradrenergic alpha-1 receptors
  - orthostatic hypotension
  - reflex tachycardia
  - low potency drugs not prescribed for persons with hypotension, heart failure or history of arrhythmias.

Action of Anti-psychotics

- BLOCKS DOPAMINE RECEPTORS
  - Causes EPS
  - Creates imbalance of ACh
  - Controlled by anti-cholinergic drugs
  - Cogentin and Artane

Anti-Cholinergic Drugs

- Given to restore balance between ACL and Dopamine
- Create side effects themselves
Anti-Psychotic Drug Side Effects

- Constipation
- Dry mouth
- Nasal congestion
- Blurred vision
- Mydriasis
- Photophobia
- Hi-fiber, increase H2O
- H2O, gum, candies
- OTC nasal decongest
- Safety, vision will clear
- Report eye pain immediately
- Sunglasses
- Hypotension/orthostatic hypotension
- Tachycardia
- Urinary retention
- Urinary hesitation
- Sedation
- Weight gain
- Rise slowly/sit-stand BPs
- Due to hypotension
- Monitor output/cath
- Awaken/activity
- Monitor diet/exercise

Anti-Psychotic EPS Effects

- Akathisias
  - Usually developed within the first 10 days of treatment
  - 20-25% will develop
  - Usually in the first 10 days of tx
  - Anti-cholinergics or clonodine or benzos
  - Jittery/restless - can’t sit still must move
  - Chief reason for non-compliance
  - Most common therapeutic intervention
  - Switching anti-psychotic drugs
  - Reduce dosages

Anti-Psychotic Drug Side Effects

- Dystonias
  - 10% of patients develop dystonias
  - 90% appear in the first three days of treatment
  - Involuntary muscle spasms
Oculogyric crises
Tongue protrusion
Torticollis
Laryngeal-pharyngeal contriction - life threatening

Akinesias
33% of the patients will develop
Most by the third week of treatment
Treated with anticholinergics
Absence of movement
Slowed movement - bradykinesia
Fatigue, painful muscles
Respond well to anti-cholinergic drugs
Artane/Cogentin

EPS Symptoms
Akathisias
Dystonias
Dyskinesias
Dysphagia
Parkinsonian symptoms such as:
Tremors
Rigidity
Bradykinesia
Loss of facial expression
20% patients develop - few weeks to months

Anti-Cholinergic Side Effects
Central Nervous System
Memory, learning and confusion
Peripheral Nervous System
Dry mouth
Nasal congestion
Urinary retention
Orthostatic hypotension – text pg. 853 for assessing

Neuroleptic Malignant Syndrome
Caused by hypodopaminergic state
Offending agents - high potency antipsychotics primarily
Agitation
Altered consciousness
Hyperreflexia
Hyperthermia
Impaired breathing
Muscular rigidity
Muteness
**AntiCholinergic Side Effects**
- Caused by blockade of cholinergic receptors
- Anti-cholinergic drugs such as the low-potency anti-psychotics and the anti-cholinergic/parkinson drugs
- Blurred vision
- Anhidrosis
- Constipation
- Diminished lacrimation
- Mydriasis
- Tachycardia

**EPS - Hypokinetic Type**
- Caused by hypo-dopaminergic state
- Offending agents - typically high potency anti-psychotics
- Akathisia
- Akinetic
- Dystonia
- Drug-induced or pseudoparkinsonism

**Hyperkinetic Type**
- Caused by nigrostriatal receptor sensitivity
- Offending agents - high potency anti-psychotics
- EPS - Tardive Dyskinesia - irreversible condition

**Assessing for EPS**
- Gait
- Arm dropping
- Cog wheeling
- Elbow rigidity
- Wrist rigidity
- Leg pendulousness
- Head dropping
- Tremor
- Akathisias
- Dyskinesias
- Dysphagia
- Dystonias

**Tardive Dyskinesia**
- *Is irreversible – no cure*
- Develops after years of antipsychotic treatment
Tardive (late onset); dyskinesia – dysfunctional movement
Abnormal Involuntary Movement Scale (AIMS) Text pg.856

Brief Psychiatric Rating Scale

- **Somatic Concerns** - concern over present bodily health
- **Anxiety/Anxiety Statements** - worry, fear, over concern for the present or future
- **Emotional Withdrawal** - deficiency in relating to others
- **Conceptual disorganization/disorganized speech** - degree to which thought processes are confused, disconnected, or disorganized
- **Guilt feelings/statements** - over concern or remorse for past behavior
- **Tension behaviors** - physical and motor manifestations of tension, “nervousness”, and heightened activation level
- **Mannerisms/posturing** - unusual and unnatural motor behavior which causes certain mental patients to stand out in a crowd of normal people
- **Grandiosity** - exaggerated self-opinion, conviction of unusual ability or powers
- **Depressive mood** - despondency, sadness, vegetative signs
- **Hostility** - animosity, contempt, threats, belligerence, disdain for other people
- **Suspiciousness** - belief (delusional or other wise) that others have now or have had malicious intent toward the patient
- **Hallucinatory behavior** - perceptions without normal external stimulus correspondence
- **Motor retardation** - reduction in energy level, evidenced in slow movements, speech, reduced body tone, decreased number of movements
- **Uncooperativeness** - evidence of resistance, unfriendliness, resentment and lack of readiness to cooperate
- **Unusual thought content** - unusual, strange, odd or bizarre thought content
- **Blunted affect** - reduced emotional tone, apparent lack of normal feeling or involvement
- **Excitement** - heightened emotional tone, increased reactivity, agitation, impulsivity
- **Disorientation** - disorientation or lack of proper association for person, place, purpose or time
- **Loss of functioning** - rate general loss of functioning - ability to perform ADLs

**Metabolic Syndrome**

- Atypical antipsychotics – 2nd generation:
  - Clozaril
  - Zyprexa
  - Seroquel
  - Risperdal
  - Geodon
  - Abilify

- Associated with weight gain and metabolic syndrome risk.
- Recommendations for monitoring clients on these drugs are:
•Before initiating assess for obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease

• **Weight**
  • *Checked at baseline then 4, 8 and 12 weeks after initiating therapy and quarterly thereafter*
  • *Dietary intervention if client is obese or weight gain occurs.*
  • *If weight gain of >5% of their initial weight – consider switching to a different agent*

• **Weight**
  • *Geodon and Abilify have been associated with less weight gain when compared to others*
  • *Waist circumference measured at baseline and then annually to assess for obesity*
  • *Blood pressure checked at baseline, 12 weeks and then minimum of annually*

**Metabolic Syndrome**
• *Laboratory Analyses*
  • *Fasting plasma glucose at baseline; 12 weeks then annually while on the medication*
  • *More often – 3-6 months for those with higher baseline risk for diabetes*
  • *Fasting lipid profile checked at baseline prior to the medication and repeated in 12 weeks then every 3 months to annually*

**Psychotropic Drugs – Other Classes**
• *Lithium – Text pg. 863-864*
• *Anxiolytics - Valium: tolerance, addiction*
• *Tricyclic antidepressants and SSRIs – Text pg. 861*
• *MAO inhibitors – monoamine oxidase inhibitors – Text pg. 862-863; Tyramine free diet*

**Psychiatric Nursing Assessment**

**Presenting Problem**
• *Symptoms*
• *Cause of most discomfort*
• *Length of problem*
• *Effects on work and relationships*
• *History of problem*
When, how, and what was helpful
What does the patient want from treatment

**Physical Dimension**
- Family health history
- Individual health history
- Growth and developmental history
- Activities of daily living
- Physical exam
- Diagnostic results

**General Appearance**
- Physical characteristics

- Style of dress
- Posture
- Eye contact
- Motor activity
- Mannerisms

**Body Image**
- Assess for:
  - Recent changes
  - Appearance - patient describes
  - Feelings about body
  - Noticeable deformities
  - Likes – dislikes
  - Desired changes
Emotional Dimension

Affect
• Facial expression
• Motor behavior
• Physical signs
• Appropriateness

Mood
• Quality of mood
• Stability of mood
• Emotional patterns

Intellectual Dimension

Sensation and perception
• See, hear, smell, taste, thoughts

Memory
• Immediate
• Recent
• Remote

Cognition
• Orientation
• Fund of information
• Judgment
• Insight
• Abstract thinking

Intellectual Dimension

Communication

Flexibility – rigidity
Social Dimension
- Self-concept
- Interpersonal relations
- Cultural factors
- Productivity
  • Employment
- Trust/Mistrust
- Dependence - Independence

Mental Status Exam
- General behavior, appearance attitude
- Characteristics of speech
- Emotional state
- Content of thought
- Orientation
- Text pps. 217-220

DSMIV-TR
- Review text pps. 226-228

Therapeutic Milieu

Therapeutic Milieu
Rubber fence - an artificial ego boundary for psychiatric and substance abusing patients

Introduction
- Definition of Milieu
- Purpose of Milieu
- Nursing Role in Milieu

DEFINITION OF MILIEU
- The term milieu means environment
- In the case of psychiatric milieu the term means a therapeutic environment within which the mentally ill patient can:
Learn to trust
– Acquire self-confidence

- The term milieu means environment
- In the case of psychiatric milieu the term means a therapeutic environment within which the mentally ill patient can:
  – Increase self-esteem
  – Progress to independence
  – Learn new skills and behaviors

Psychology of the Milieu

- The psychiatric milieu can be conceptualized as an artificial ego boundary within which the patient can test out new behaviors in a safe environment

- Viewed as a rubber fence (metaphor) surrounding the unit - the patient can bounce against the rubber fence but cannot break it

COMPONENTS OF THE THERAPEUTIC MILIEU

- Boundary Forces
  – Those elements that create safety and security for the patient within the milieu
- Treatment Structure
  – Those elements that create structure and formulate the “treatment” effects within the milieu
  – Often referred to as milieu therapy

Level or Phase System

- Unit Rules and Guidelines
- Policies and Procedures
- Recovering Patients
- Bricks n’ Mortar

Level System

- Unit Rules
- Recovering Patients
- Policies and Procedures
- Bricks ‘n Mortar

Treatment Structure

- Treatment Program
- Individual Interactions
- Community Support Groups
- Multi-disciplinary team
- Therapeutic Community
NURSING MANAGEMENT OF THE MILIEU

Nurses are responsible for creating, monitoring and maintaining elements crucial to the functioning of the milieu
Nurses are responsible for monitoring the effectiveness of the Boundary Forces and Treatment Structure
Nurses provide the necessary communication links among all elements
Nurses are responsible for creating, monitoring and maintaining elements crucial to the functioning of the milieu
Nurses are responsible for monitoring the effectiveness of the Boundary Forces and Treatment Structure
Nurses provide the necessary communication links among all elements

ASSESSING THE MILIEU - BOUNDARY FORCES

Level or phase system
- Are the staff oriented to the system
- Do staff explain the system to patients
- Do staff maintain consistency across shifts and disciplines

Unit rules and guidelines
- Are guidelines written and given to patients
- Do all staff enforce guidelines
- Are there numerous patient restraint/seclusion

BOUNDARY FORCES

Policies and procedures
- Do policies and procedures reflect patient/staff safety
- Are all staff oriented to the policies/procedures
- Are new policies developed and existing ones revised
- Are policies consistently enforced

Recovering patients
- Are recovering patients paired with newly admitted patients in a “buddy system”
- Are recovering patients involved in communicating the boundary forces and treatment structure to the new patient
- Is the behavior of recovering patients monitored for appropriateness

Bricks n’ Mortar
Do staff routinely assess the environment for cleanliness and safety
Are patients expected to take responsibility for the cleanliness of the milieu
To the rules and guidelines include appropriate decoration and utilization of the milieu including the patient rooms

TREATMENT STRUCTURE

- Treatment program
  - Is the program defined and implemented consistently
  - Is the program comprehensive enough to address the diagnostic needs of the patients being served
  - Are families involved in the program

TREATMENT COMPONENTS

- Group psychotherapy
- Individual therapy
- Therapeutic Community
- Process group therapy
- Didactic group therapy
- Recreational therapy
- Conducted daily

TREATMENT STRUCTURE

- Individual interactions
  - Do nursing staff schedule regular one-to-one interactions with patients
  - Are patient needs acknowledged immediately by the nursing staff
  - Are potentially dangerous incidents addressed immediately
- Multi-disciplinary team
  - Do staff consult with one another across disciplines
  - Is there an integrated treatment plan
  - Are all disciplines involved in developing treatment protocols
  - Do all staff assume responsibility for the safety of the milieu
- Therapeutic community meetings
  - Do the nursing staff hold therapeutic community meetings that are goal oriented
  - Are all unit staff involved in community meetings
  - Do patients participate in community meetings
  - Are community meetings used to solve problems within the milieu and define goals
- Community support groups
  - Do patients participate in community support groups (inpatient, outpatient or both)
  - Are staff supportive of patient attendance at support group meetings

SUMMARY

- The Therapeutic Milieu is a powerful mechanism for patient change
- Given acuity and the shortened lengths of stay the milieu must be very intensive and goal oriented
- Ineffective milieus are characterized by patient aggression, elopements, AMAs and numerous seclusion/restraint episodes

**LECTURE WEEK # 3**

**COMMUNICATING WITH THE PSYCHIATRIC PATIENT**

**PRESENTATION OVERVIEW**
- Communicating with the delusional patient
- Communicating with the hallucinating patient
- Communicating with the patient experiencing illusions

**COMMUNICATING WITH THE DELUSIONAL PATIENT**
- A delusion is a false belief - it cannot be argued away
- Delusions are a form of psychological protection for the patient
- A patient’s delusions tell the nurse-therapist a great deal about the patient’s thinking, feelings and fears

**ASSESSING DELUSIONS**
- Listen carefully to the patient’s delusional beliefs - do they contain homicidal or suicidal content?
- Have the delusions changed abruptly?
- Is the patient NOW working you or another staff member/s into the delusion?
- Is the patient more secretive about the delusion than before?

**COMMUNICATION INTEVENTIONS**
- Claude Steiner (The Radical Therapist) says - validate the part of the delusion that is real
- Deflect to the feelings implied by the delusion
- Utilize reality orientation by stating the perceived reality of the nurse-therapist
- Invalidate the delusion

**COMMUNICATION - THE HALLUCINATING PATIENT**
- Hallucinations are false sensory experiences
- They are unlike illusions which are MIS-interpretations of sensory experiences
- The most common hallucinations are auditory
- There is some indication that the person plays a role in the creation of the voices
NATURE OF HALLUCINATIONS
- Hallucinations usually begin by being very bequiling and complementary - then change to being accusatory, menacing and threatening
- Hallucinations often disrupt the patient’s ability to sleep, concentrate and participate in activities
- Patients often guard their hallucinations

ASSESSING HALLUCINATIONS
- Always determine FIRST if the voices are telling the patient to kill themselves or someone else
- Do not reinforce the validity of the voices but check to see what they are saying to the patient
- Indicate that you know the patient is hearing speaking to voices

COMMUNICATION INTERVENTIONS
- Voice dismissal
- Distraction to concrete tasks/activities
- Dis-avow the reality of the voices
- Deflect to the feelings underlying the voices
- Engage the patient in an interaction
- If in the Day Room - the TV seems to decrease hallucinations

COMMUNICATION STRATEGIES
- Assure the patient that you will not let him be hurt
- Provide chemotherapy
- Always be empathetic - this is a very distressing occurrence for the patient
- Listen to the messages in the patient’s hallucinations
- Find humor in private - never with the patient

COMMUNICATION - ILLUSIONS
- An illusion is a mis-interpretation of sensory perception
- Distract the patient
- Dis-avow the reality of the illusion
- Chemotherapy

SUMMARY
- Effective communication is critical in all aspects of patient care but even more so in the care of the psychiatric and addicted patient
- Practice the rules, correct the errors and engage with those patients who have distortions such as delusions and hallucinations
MANAGING ANXIETY

Basic Concepts About Anxiety
• The threat that causes anxiety may be real or perceived
• Behaviors used to cope with anxiety may be
  – Adaptive
  – Palliative
  – Maladaptive
  – Dysfunctional

Principles of Anxiety
• Anxiety is a subjective experience that can be detected only by the objective behaviors that result from it
• Anxiety is experienced as emotional pain, fear, apprehension, fearfulness or powerlessness
• Anxiety is a warning sign of danger
• Reality testing is intact in anxiety
• Anxiety is due to a perceived loss or threat to the self
• Thought blocking may occur in severe anxiety

Principles of Anxiety
• Anxiety triggers a response in behaviors called: relief behaviors
• Anxiety occurs in degrees
• Anxiety is contagious

Coping Methods
• Adaptive coping - solves the problem causing the anxiety so anxiety is decreased
• Palliative coping - temporarily decreases the anxiety but does not solve the problem
• Dysfunctional coping - not successful in reducing anxiety or solving the problem

Interventions - Mild to Moderate
• Help patient identify anxiety
• Anticipate anxiety escalating
• Use calm, caring approach
• Encourage expression of feelings

• \textit{ventilation} + \textit{validation} = \textit{relief}

• Utilize open ended communication - allow patient to explore areas of distress

• Encourage problem solving

• Explore behaviors that have worked before

• Provide outlets for working off excess energy

\textbf{Interventions - Severe to Panic}

• Maintain a calm manner

• Remain with the patient

• Reduce environmental stimuli

• Use clear/simple statements with repetition if necessary

• Use low pitched voice

• Reinforce reality if distortions occur

• Listen for themes

• Attend to physical needs

• Set limits in a firm voice

• Increase physical movement

• Assess need for medication or seclusion

\textbf{Systemic Interventions}

• Walk and talk

• Time out/quiet time in room

• Medication

• Seclusion

• Restraint

• Due to thought blocking patient may have difficulty communicating - REDUCE external stimuli
SUMMARY
• A certain amount of anxiety is needed to learn, assess the environment and grow as a person
• Too much anxiety decreases the ability to incorporate and respond to stimuli
• Panic levels of anxiety are very frightening to experience; immediate interventions must be taken

DEFENSE MECHANISMS

Ego Defense Mechanisms Across the Life Cycle
• Level I: Psychotic Mechanisms - in psychosis, dreams and childhood
  – Denial
  – Distortion
  – Delusional projections

• Level II: Immature Mechanisms - in severe depression, personality disorders, adolescence
  – Fantasy - schizoid withdrawal, denial through fantasy
  – Projection
  – Hypochondriasis

• Level III: Neurotic Mechanisms
  – Intellectualization (isolation, obsessive behavior, undoing, rationalization)
  – Repression
  – Reaction formation
  – Displacement
  – Dissociation

• Level IV: Mature Mechanisms - common in healthy adults
  – Sublimation
  – Altruism
  – Suppression
Anticipation
Humor

PURPOSE OF DEFENSE MECHANISMS

• The purpose of defense mechanisms is to **defend the ego** (personality) against a perceived threat and anxiety
• Defense mechanisms can be maladaptive and adaptive
• Generally these mechanisms are thought to inhibit insight and personal growth

TYPES OF DEFENSE MECHANISMS

• Repression
• Denial
• Suppression
• Rationalization
• Reaction formation
• Compensation
• Conversion
•Undoing
• Dissociation
• Intellectualization
• Sublimation
• Displacement

NURSING INTERVENTION

• Supportive of defensive structure
  – *Empathy for anxiety*
  – *When patient has fragile or poorly integrated ego structure*
• Confrontive of defensive structure
  – *When patient's ego structure is immature but intact*

TRANSFERENCE

– *A process whereby the patient transfers unconscious materials onto the nurse and nurse-patient interactions*

COUNTER-TRANSFERENCE

• A process whereby the therapist or nurse transfers unconscious materials onto the patient and patient interactions in response to transference
SUMMARY

• Even Freud said sometimes a cigar is just a cigar
• Patients are the best barometers for the amount of insight they can handle
• Respect the patient’s right to be where s/he is
• Timing and relationship are a must in confronting any psychogenic issues

LECTURE WEEK # 4

AWARENESS AND THERAPEUTIC CONFRONTATION

CONCEPT OF AWARENESS

• Awareness is often called insight in psych
• Self-awareness is a key component of perception and reality orientation
• Awareness or insight is comprised of four components: psychological, physical, environmental, philosophical

PSYCHOLOGICAL AWARENESS

• Knowledge of emotions, motivations, self-concept and personality. Being sensitive to one’s own feelings and to external elements that affect feelings

PHYSICAL AWARENESS

• Knowledge of personal and general physiology, bodily sensations, body image and physical potential

ENVIRONMENTAL AWARENESS

• Knowledge of the social environment, relationships with others, knowledge of the relationships between humans

PHILOSOPHICAL AWARENESS

• Sense that life has meaning - includes values, morals and such phenomena as empathy and compassion
SELF-DISCLOSURE

• Self-disclosure is a symptom of personality growth, health and a means of developing a healthy personality

• Symptoms of mental illness and dysfunctional relationships are fraught with secrets, fearfulness and misinterpretations of reality - all outcomes of impaired awareness and avoidance of self-disclosure

THE JOHARI WINDOW

• The Johari Window is a metaphor for the Window of Awareness

• It was first developed by Joe Luft and Harry Ingram

• The goal of self-awareness is to enlarge quadrant 1 of the Johari Window

—FOUR PANED WINDOW OF AWARENESS

DEVELOPING AWARENESS

• To increase self-knowledge the person must pay attention to genuine emotions, identify and accept personal needs, explore thoughts, feelings, memories and impulses

• The goal of self-awareness is to enlarge the area of quadrant 1 while reducing the size of the other three

• To reduce the size of Quadrant 2 the person listens to others - self-knowledge is not possible alone

• Quadrant 3 is reduced by self-disclosing - revealing to others important aspects of the self

• No one comes to know him/herself without self-disclosing to another person

THERAPEUTIC CONFRONTATION

• Therapeutic means to improve or help toward healing

• Confrontation means to address or face

• It is not negative or attacking

• Therapeutic confrontation is used to assist the patient in developing self awareness

PURPOSE OF THERAPEUTIC ONFRONTATION

• The purpose of therapeutic confrontation is to raise the level of the person’s self awareness

• It is done with caring and kindness

• It is done as though a mirror is being held up for the person to see behaviors
Timing is the most critical aspect of therapeutic confrontation

THE WINDOW OF AWARENESS

<table>
<thead>
<tr>
<th>Known to others</th>
<th>Not known to others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to self</td>
<td>Not known to self</td>
</tr>
</tbody>
</table>

SUMMARY

• The Johari Window is a theoretical and metaphorical strategy for conceptualizing the phenomenon of awareness
• Self-awareness is a major component of mental health, a healthy personality and self-actualization
• Therapeutic confrontation is designed to increase self-awareness and self-control

LECTURE WEEK # 5

MANAGING ANGER AND AGGRESSION

Intervening In Anger

• There are three categories of situations that provoke anger
  – Frustration/frustrating situations
  – Situations where the person’s sense of adequacy/security are threatened
  – Situations where one person’s behavior does not meet the expectations or approval of another

Interventions

• Reduce or eliminate the frustrating situation
• Encourage expression of feelings
• Identify and discuss expectations
• Implement the problem-solving process

Levels of Aggression

• Level I – Potential
  – Increase in demands, irritability, complaints, sarcasm
–Mild to moderate anxiety – sudden mood changes, change in voice tone, rate of speech, restlessness, increased motor activity

–Is able to perceive, communicate and problem solve

**Nursing Goals - Level 1**

• Identify the threat and analyze ways to manage it
• Increase awareness of underlying feelings – encourage appropriate expression
• Reduce anxiety
• Use resources to solve rather than act out feeling

**Nursing Interventions – Level 1**

• Observe, recognize and acknowledge patient’s feelings
• Encourage verbalization
  –Help patient specify anger
  –Connect to feelings, thoughts and behaviors
  –Separate feelings from action
• Assist in insight development – identify the threat, frustration, expectation
  –Investigate situation immediately preceding the aggression
• Help patient explore possible consequences to behavior
• Determine what can be done to remove threat

**Levels of Aggression**

• Level 2 – Impending
  –Provoking arguments with others – threats and accusations
  –Moderate to severe anxiety
  • Change in affect or behavior
  • Increased tension and anxiety
  • Limited focus of attention, reduced ability to perceive and communicate

• Level 2 – Impending
  –Somatic changes – rapid breathing, heart rate, muscular tension, flushing, perspiration

**Nursing Goals - Level 2**

• Express feelings verbally rather than by aggressive acts
• Maintain safety for patient and others with external controls
• Release tension through expenditure of energy
• Regain sense of control by elimination of external stressors, threats when possible
**Nursing Interventions – Level 2**

- Encourage verbalization of feelings
- Help patient isolate threat/frustration
- Reduce stress when possible:
  - Offer medication
  - Reduce environmental stimulation
  - Provide environmental control
- Explore consequences of behavior
- Separate thought from action
- Set consistent and fair limits
- Respond in clear, simple statements
- Reality orient
- State expectation that patient will gain control

**Levels of Aggression – Level 3**

- Level 3 – Immediate
- Destructiveness toward animate and inanimate objects
- Severe or panic anxiety
  - Scattered attention, easily distracted, confused
  - Inability to communicate or function
  - Reduced comprehension
  - Marked somatic responses

**Nursing Goals – Level 3**

- Immediate establishment of safety for the patient and others
- Reduction of agitation, tension and anxiety
- Regained sense of self-control

**Nursing Interventions – Level 3**

- Provide temporary physical and environmental controls
- Give medication if ordered
- Communicate with brief, clear, direct responses
—Tell patient what is happening – assure patient you will stay with him/her
• Do not introduce any new material for processing

• Assure the patient staff will help him/her control the behavior with external means

• Monitoring for Aggression
  • Assess the precursive signs
    – Increase in motor agitation
    – Threatening verbalizations/gestures
    – Intensification of affect
    – Responding to threatening hallucinations
    – Prior history of aggression
    – Use of alcohol or drugs

Intervening in Aggression
• Reduce stimuli by withdrawing from the environment any object/person frustrating the patient
• Put distance between the patient and the intervener
• Explain who you are
• Give assurance by exploring what’s happening

Intervening
• Give the patient choices
• Attempt to find the source of the problem and correct it
• Get help - increase the number of interveners
• Chemotherapy
• Physical restraint

CRISIS INTERVENTION
• Attributes of crisis

— Crisis is both a critical situation and an opportunity

— Crisis is an acute, time-limited condition causing disequilibrium

— The person is temporarily unable to cope with or adapt to the stressor by using previous methods
ATTRIBUTES

• Crises are often turning points or junctures in a person’s life

• Unsuccessful resolution of a crisis typically leaves the person feeling anxious, threatened and unable to manage normal activities

• All crises are experienced as sudden occurrences

• The crisis is perceived as life-threatening even if this is not realistic or rational

• There may be a sense of real or perceived displacement from normal reality

• All crises are accompanied with a sense of loss - perceived or real. Losses can be an object, person, hope, dream, health, independence, body image

• The impact of the crisis can be altered by the health care provider

• The progression to mental or emotional illnesses can be prevented by the caring and attentive management of the crisis situation

SEQUENCE OF CRISIS

• Pre-crisis stage
  • The stage of maintaining or attempting to maintain equilibrium. When successful the person avoids a crisis and reverts to dynamic equilibrium

• Crisis stage
  • A reaction to a stimulus such as an event, situation or trauma. It is not the stimulus but the perception of it. The nature of the reaction is highly individualized

• Post-crisis stage
  • During this stage the person arrives at or develops a new steady state. This new state may resemble the pre-crisis state or be more positive or negative

CRISIS BALANCING FACTORS

• Perception of the event

• How the person perceives the crisis is crucial to its resolution
• Situational support
• Adequate support derived through interpersonal relationships is crucial to resolution
• Coping mechanisms
• The effectiveness of past coping mechanisms to relieve anxiety and tension alter the effect of the crisis

ROLE OF THE NURSE

• Assess the patient physically, psychologically and emotionally
• Assess the patient’s perception of the event/trauma - “Tell me what’s going on with you right now”; “What are you feeling”; “What are you thinking about this?”
• Utilize the patient’s social support system when available
• Become a balancing factor for the patient
• Explore coping mechanisms and new methods of coping

SUMMARY

• Attributes of crises
• Sequencing factors
• Balancing factors
• Role of the nurse

Crisis Management

Attributes of Crises

○ Viewed as both a critical situation and an opportunity
○ Is acute, time-limited condition causing disequilibrium
○ Person is temporarily unable to cope with or adapt to the stressor
○ Often are turning points in people’s lives
○ Unsuccessful resolution of a crisis leaves the person feeling anxious, threatened and unable to handle daily stressors
○ All crises are sudden occurrences
○ The crisis is perceived as life-threatening
○ There may be a sense of real or perceived displacement from normal reality, familiar surroundings or significant others
 ○ All crises are accompanied with a sense of loss - perceived or real
○ Impact of the crisis can be altered by the behavior of the health care provider
○ Progression to mental and emotional illnesses that accompany physical illnesses can be prevented by the CARING and ATTENTIVE management of the crisis
Sequence of Crisis

- Pre-crisis stage

- Crisis stage

- Post-crisis stage

Pre-Crisis Stage
- The stage of maintaining or attempting to maintain equilibrium. When successful the person avoids a crisis and reverts to a state of dynamic equilibrium.

Crisis Stage
- A reaction to a stimulus such as an event, situation or trauma. It is not the stimulus itself. The nature of the reaction is highly individualized but always involves a sense of disequilibrium for the individual.

Post-crisis stage
- During this stage the person arrives at or develops a new steady state. This state may resemble the pre-crisis condition or may be more positive or negative.

Balancing Factors
- Perception of the event
- Situational support
- Coping mechanisms

Perception of the event
- How the person perceives the crisis is crucial to its resolution. Whether the crisis is viewed realistically or distorted is a critical element.

Situational support
- Adequate support derived through interpersonal relationships is crucial to the effective resolution of the crisis.

Coping mechanisms
- The effectiveness of past coping mechanisms to relieve anxiety and tension alter the impact of the crisis and give the person time to meet the challenge.

Role of the care-giver
- Assess the patient’s status - how does the patient look?
Assess the patient’s perception of the event/trauma - “Tell me what’s going on with you right now? What are you thinking about this news? What are you feeling?

Utilize the patient’s social support system when trauma is expected - “We have some information to discuss and some decisions to make. Who would you want to bring with you?

Become a balancing factor for the patient by providing empathy, offering to contact a supportive other, stay with patient until someone arrives, do follow-ups to see how the patient is doing

Refer to support groups or other treatment

LECTURE WEEK # 6

PSYCHOSES - SCHIZOPHRENIA

FUNCTIONAL DISORDERS

• An alteration in cognition or affect that results from learning/neurochemistry thereby modifying the brain

• Psychotic disorders - disintegration of the personality and loss of contact with reality

• Affective disorders - disintegration of affect, change in intensity, inappropriate, uncanny

Psychotic Disorders

• Characterized by thought disorders, disruptions in communications and loss of contact with reality
  – Schizophrenia
  – Paranoia
  – Psychotic depression

Affective Disorders

• Depression
• Mania
• Manic-Depression (Bipolar)

12 Signs and Symptoms of Schizophrenia

• Restricted affect
• Poor insight
Absence of early awakening
• Poor rapport
• Lack of depressed facial affect
• Lack of elation
• Incoherent Speech
• Wide spread delusions
• Unreliable information
• Bizarre and fixed delusions - thought broadcasting
• Auditory hallucinations
• Withdrawal - social isolation

**Schneider’s First and Second Rank Symptoms**

• **First Rank**
  – *Hearing thoughts spoken aloud*
  – *Auditory hallucinations*
  – *Somatic hallucinations*

• **First Rank**
  – *Delusions*
  • *Thought broadcasting*
  • *Thought insertions*
  • *Thought control*
  • *Thought influence*

• **Second Rank**
  – *Other types of hallucinations*
  – *Depressions*
  – *Euphoria*
  – *Perplexity*
  – *Emotional blunting*

**Blueler’s Four A’s**

• Affective disturbance
• Associations - disordered
• Autism
• Ambivalence
Type I and Type II

• Type I - positive: characterized by delusions, hallucinations, thought disorder, disorganized speech, disorganized or catatonic behavior

Type I and Type II

• Type II - negative: affective blunting, reduced fluency and abundance of thought alogia, avolition and anhedonia

Speech and Thinking Disorders

• Echolalia
• Circumstantiality
• Loose associations
• Tangential
• Flight of ideas
• Word salad
• Clang associations
• Repetitive words
• Detailed lengthy
• Absent connections
• Topic change-parallel
• Topic rapid
• Word strings
• Repetitive word similar in sounds

Speech and Thinking Disorders

• Neologisms
• Paranoia
• Referential thinking
• Autistic thinking
• Concrete
• Made up words
• Suspicious
• Stimuli relate to self
• Literal, immediate, own logic
• Lack of abstraction

Interventions

• Frequent, short and non-demanding interactions
• Plan one-to-one simple activities
• Assume non-committal approach to bizarre behavior
• Seek clarification of communication
• Introduce patient to group activities

**ADLs and safety**
• Allow as much control and autonomy as possible
• Establish trust through short interactions demonstrating interest
• Handle medication refusal by firm, matter-of-fact approach
• Explain treatments, medications, labs
• Do not reinforce hallucinations
• Confront delusions/hallucinations
• Respond to feelings patient is communicating by alterations
• Engage in physical activity
• Reduce stimuli if feeding alterations

**If agitated:**
– Try to find out what’s causing agitation and correct it
– Assess for impending violence
– Decrease stimuli
– Provide physical outlet - verbal, kinesthetic
– Set limits
– Isolate if necessary
– Chemotherapy if necessary
– Show of force in number
– Isolation/seclusion
– Restraint
Schizophrenia - Types
• Paranoid
• Disorganized
• Catatonic
• Undifferentiated
• Preoccupied with delusions, hallucinations
• Disorganized speech, behavior, affect
• Immobility, stupor, posturing
• Doesn’t meet subtypes

Schizophrenia
• Genetics - twin studies
• Dopamine theory - excessive
• Brain structure - ventricles
• Complex of more than one illness
• Some interdependence between environment and disease

Violence in the Psychiatric Setting

Precursors of Violence
• Elements of frustration
• Brain Chemicals
• Learned behavior
• Mental illness - neurochemicals
• Past history of violence - aggression
• Substance abuse
• Aggressive impulsivity - abnormalities in serotonin and noradrenergic system
• Low GABA
• High Dopamine

Systemic prevention
• The Therapeutic Milieu
• Communication
• Management of aggressive behavior training

Critical thinking Q?
What steps would you enact if someone appears angry?
Critical Incident Stress Management (CISM)

- Critical Incident Stress Management (CISM) is an intervention strategy designed to reduce the effects of acute mental and emotional disruptions associated with psychological trauma and to prevent the development and progression of posttraumatic stress disorder (PTSD).

- This intervention is important for psychiatric nurses working in and/or administering mental health programs. The likelihood of an aggressive episode in a psychiatric setting is greater than in any other area where nurses are employed except the emergency room.

- The effects of unresolved psychological trauma precipitated by a critical event may include physical illnesses, permanent disability, depression and the complex condition of PTSD.

- The goal of CISM is to provide early intervention as a form of prevention to avoid progression of psychological and physiological problems. The Table below depicts a model that is used for groups and/or individuals in managing these crises.

- In anticipation of such events in psychiatric hospitals all clinical hospital staff are trained in the management of aggressive and assaultive behavior.

- These programs are usually commercially prepared and provided by experienced trainers.

- The pre-training to handle these critical events is a crucial component of reducing the lethality of the event itself and providing pre-crisis preparation

Critical Incident Intervention

- Pre-crisis preparations for both individuals and organizations
- Group briefing procedures for use with large numbers of individuals
- Individual crisis intervention strategies
- Small group discussions - called defusings
- Large group discussions focusing on cognitive-emotional-cognitive interventions usually lasting 1-3 hours and occurring within 2-7 days of the event. This strategy involves:
  - Evaluate the facts, thoughts and emotions of the event
  - Consider possible symptomatology associated with PTSD
  - Identify strategies for coping
- Large group discussions
  - Evaluate the facts, thoughts and emotions of the event
  - Consider possible symptomatology associated with PTSD
  - Identify strategies for coping
- Family crisis intervention

- Follow-up for continued counseling and treatment


**LECTURE WEEK # 7**

**AFFECTIVE DISORDERS**

*Types of Affective Disorders*

- Major depression
- Mania
- Bipolar disorder

**MAJOR DEPRESSION**

- At least five of the following - including one of the first two; present most of the day - every day for two weeks:
  - Depressed mood
  - Loss of interest or pleasure
  - Weight gain or loss
  - Insomnia or hypersomnia
  - Psychomotor retardation/agitation

- At least five of the following - including one of the first two; present most of the day - every day for two weeks:
  - Fatigue or loss of energy
  - Feelings of worthlessness/excessive guilt
  - Impaired concentration/indecisiveness
  - Thoughts of suicide or death

**Exogenous vs Endogenous**

- Exogenous - external situational/psychogenic
- Endogenous - originating from within/biochemical
  - DST - Dexamethasone Suppression Test
  - Thyrotropin Releasing hormone infusion test

**Behaviors Associated With Depression**

- Anger
- Anxiety
- Apathy
- Guilt
- Helplessness
- Hopelessness
• Insomnia
• Fatigue
• Anorexia
• Chest pain
• Constipation
• Headache
• Nausea
• Confusion
• Inability to concentrate

**Vegetative Symptoms**

• Constipation
• Anorexia
• Sleep disturbance

**MANIA**

• Three or more of the following:
  – Inflated self-esteem
  – Decreased need for sleep
  – Pressured speech
  – Flight of ideas
  – Distractibility
  – Psychomotor agitation

**Behaviors Associated With Mania**

• Elation
• Euphoria
• Intolerance of criticism
• Lack of shame or guilt
• Dehydration
• Inadequate nutrition
• Weight loss or gain
• Distractibility
• Flight of ideas
• Illusions
• Impaired judgment
• Loose associations
• Denial of danger
• Aggressiveness
• Excessive spending
Behaviors Associated With Mania

- Poor grooming
- Increased motor activity
- Irresponsibility
- Argumentativeness
- Inadequate sleep
- Hyper-sexual
- Verbosity
- Provocativeness

MANIA

- Three or more of the following:
  - Excessive involvement in pleasurable activities that may lead to negative outcomes
  - Grandiose delusions
  - Labile mood with rapid swings from anger to crying to laughing

BIPOLAR DISORDER

- Bipolar I
  - That is alternating moods, sadness, irritability or euphoria accompanied with symptoms of depression or mania
  - Person has experienced one or more manic episodes or mixed with depression
  - The person may also experience episodes of depression

BIPOLAR DISORDER

- Bipolar II
  - Recurrent episodes of major depression with episodic hypomania
  - The person has never demonstrated an episode of mania

CYCLOTHYMIC DISORDER

- Chronic mood disturbance of at least 2 years duration involving episodes of hypomania and depressed mood but does not meet Bipolar I or II

NURSING INTERVENTIONS

DEPRESSION/MANIA

- Modify the patient’s environment
- All patients with mood disorders are at high risk for suicide
- Monitor environment for safety
• Decrease stress in environment by interaction/activity
• Establish 1:1
• Both depressed and manic patients resist involvement in a therapeutic alliance; accept ance, persistence and limit setting are necessary
• Establish 1:1
  – With the depressed patient
• Develop rapport
• Allow patient time to respond
• Personalize the care
• Be alert to manipulation
• Reinforce patient self-control and positive behavior
• Assist in the patient’s recognition and expression of emotions
• Patients with severe mood disturbances have difficulty identifying and expressing feelings
• Demonstrate acceptance and emotional responsiveness
• Acknowledge pain and convey a sense of hope
• Help patient experience and express
• Aid the patient in modifying his negative cognitive set
• It is the perception and belief about events that create the emotional reaction
• Review with the patient his view of problems
• Identify negative thoughts and teach interruption, substitution, positive self-talk
• Aid the patient in modifying his negative cognitive set
• Teach positive thinking strategies
• Examine accuracy of perception
• Teach appropriate expression of anger
• Identify misperceptions, distortions, irrational
• Aid the patient in modifying his negative cognitive set
• Decrease the importance of unattainable goals - focus on short-term attainable goals
• Limit amount of negative evaluation he is allowed to engage in
• Activate the patient in a realistic goal-directed manner
• Assign action oriented therapeutic tasks
• Encourage physical activity and energy is mobilized
• Focus on present - not past or future
• Reinforce success
• Increase patient interpersonal involvement
• Focus on positive social skills; teach new skills
• Encourage increasing socialization
• Support family involvement in social interactions
• Support groups
COGNITIVE DISTORTIONS

• All or none thinking
• Over-generalizing
• Mental filter
• Disqualifying the positive
• Jumping to conclusions
• Catastrophizing
• Tyranny of the should
• Labeling-mislabeling
• Personalization

COGNITIVE RESTRUCTURING

• Goal - To develop alternative thought patterns to existing distorted view of self and world
  – Teach that self-statements mediate emotional arousal
  – Teach link between irrational thoughts and behavior
  – Identify dysfunctional thinking patterns
  – Increase expression of negative feelings
  – Confront faulty interpretation of events
  – Replace interpretations with reality based thoughts
  – Use humor when appropriate

SUMMARY

• Managing patients with affective disorders can be very challenging.
• When treated inpatient they need consistency, empathy, attentiveness to manipulation and a therapeutic milieu that confronts negative behaviors and thoughts.

PSYCHIATRIC HOTLINE

• Hello, welcome to the psychiatric hotline
• If you are an obsessive-compulsive, please press 1 repeatedly.
• If you are co-dependent, please ask someone to press 2 for you
• If you have multiple personalities, please press 3, 4, 5, and 6
• If you are paranoid-delusional, we know who you are and what you want. Just stay on the line so we can trace the call
• If you are schizophrenic, listen carefully and a little voice will tell you which number to press
• If you are manic-depressive, it doesn’t matter which number you press. NO ONE WILL ANSWER!
SUICIDE ASSESSMENT

Suicide Assessment – General Risk Factors

• Ideation (I)
• Substance Abuse (S)
• Purposelessness (P)
• Anxiety (A)
• Trapped (T)
• Hopelessness (H)
• Withdrawal (W)
• Anger (A)
• Recklessness (R)
• Mood Change (M)

– Mnemonic: Is Path Warm

Suicide Lethality Assessment Scale

Myths and Facts

• It is a myth that talking to someone about their suicidal feelings will cause them to commit suicide
  – Fact: Asking someone about their suicidal thoughts may make the person feel relieved that someone recognized their emotional pain

• It is a myth that all suicidal people want to die and there is nothing that can be done about it.
  – Fact: Most suicidal people are ambivalent, that is, a part of them wants to die but a part wants to live

• It is a myth that people who talk about committing suicide never actually do it..
  – Fact: When someone talks about suicide he/she may be giving a warning signal that should not be ignored by others.

• It is a myth that there is a typical type of person who commits suicide...
  – Fact: The potential for suicide exists in all of us. There is no typical type of suicidal person....suicide occurs without warning.
  – Fact: Many people, including adolescents, give warnings of their suicidal intent.

No Suicide Safety Plan

• I, __________, agree not to perform any self-destructive acts while a patient on this unit. I promise to seek out a staff member when I feel sad, lonely, nervous, frightened, and/or self-destructive.
  • _______ Patient _______ Date
  • _______ Witness _______ Date
**Instructions for Safety Plan**

• Read the contract to the patient.
• Have the patient sign the contract with two staff members as witnesses.
• Place one copy of the contract in the patient’s chart/give one copy to the patient.
• Have the patient re-read and report its importance 4 X in 24 hours.

**SUICIDE POLICIES AND PROCEDURES**

• Rounds are to be made every fifteen minutes on all patients on the psychiatric unit
• Suicide monitoring
  – Staff watch - q 15 minutes
  – Staff close - within view of staff at all times (Line of sight)
  – Staff constant - one-to-one around the clock or while awake

**INTERVENING IN SUICIDE**

• Individual sessions
  – Expression of anger turned inward
  – Find the ambivalence and press the positive
  – Assess for plan, method, means
  – If inpatient, check mouth for swallowing medications
  – Assess for plan, method, means
• Plan - “Are you thinking of hurting yourself?” “Have you thought of suicide?”
• Method - “If you could do it how would you do it?”
• Means - “Do you have guns in the home?” Or pills, or a car with access to a bridge, etc.

• Individual sessions
  – Cognitive restructuring - confront distortions
  – Problem-solving process

**SUICIDE HOT LINE**

• Establish rapport and caring concern for the patient
• Assess lethality of the plan - does patient have gun, near highway
• Get the patient to tell you where they are or agree to come in for an assessment
  – Call police if you know where patient is
  – If there is someone there with them ask them to call them to the phone
GESTURES VS ATTEMPTS

• Secondary gain - attention getting, getting even, etc.
• Evaluate the lethality of the gestures
• Always believe that the patient is at risk for accidental success or deliberate success in a gesture or attempt
• Never take a threat lightly

Cognitive-Behavioral Therapy

Lecture Objectives: Discuss

• Significance of cognitive therapy (CBT)
• Concepts of cognitive therapy (CBT)
• Interventions and strategies

Significance of CBT

• Cognitive behavioral therapy is the psychotherapy best supported by the research literature as working well with anxiety disorders, phobias, personality disorders, depression and crisis.
• Treatment with cognitive behavioral therapy, and treatment effects have been found to last for 5 years or more

Definition of CBT

• Cognitive behavioral therapy is actually a combination of therapies meant to address the physical, cognitive and behavioral aspects of anxiety.
• The physical component involves the management of physical symptoms using a combination of relaxation techniques.
• These include diaphragmatic breathing, progressive relaxation and guided visualization.
• The cognitive component is called cognitive restructuring, and the behavioral component is called exposure.
• Relaxation techniques are readily available through self-help books tapes, so the remainder of this presentation will focus on cognitive restructuring and exposure.

Concepts of CBT

• Cognitive Restructuring
  – Cognitive restructuring is based on Beck and Emery’s (1985) cognitive theory that describes anxiety and other negative emotions as products of faulty thinking.
  – Treatment consists of correcting this faulty or illogical thinking by repeatedly confronting cognitive distortions with discrepant information.
This information comes from everyday experience, role-playing, and homework assignments. The entire procedure is carried out in four steps described in the following slides.

**Steps of CBT**

*Step 1: Elicit automatic thoughts*

- **Automatic thoughts** are habitual ways of thinking. They usually occur spontaneously. When they do not, a couple of techniques may be used to elicit them.
  - **Recall by Association** - focus on the other components of anxiety (e.g., physical symptoms, behavior), and ask for associated thoughts.
  - **Focus on the image of being anxious in a social situation** and ask for whatever words come to mind.

*Step 2: Identify underlying irrational beliefs*

- Examine the automatic thoughts for any cognitive distortions that may be present.
  - These cognitive distortions usually occur as one of any number of unrealistic or irrational beliefs that can be reduced to two basic thinking errors
    - **Errors of probability overestimation** reflect the tendency to blow things out of proportion by making unpleasant events seem more likely.
    - **Catastrophizing** errors do their damage by making unpleasant events seem as though they are unbearable and could go on forever.

  Two techniques commonly used to help identify irrational beliefs are the **downward arrow technique** and the use of **thought records** to find common themes.
  - The downward arrow technique consists of challenging statements people make about what they think is causing their negative mood states by repeatedly asking the question, "If that were true, why would it be so upsetting?"
  - Thought records are a common form of homework given to people in cognitive behavioral therapy that require them to record their automatic thoughts associated with problem situations (e.g., fears) during the week.

*Step 3: Challenge the irrational beliefs*

- Once the irrational belief underlying an automatic thought has been identified, it is important to refute these beliefs by examining the evidence for them, and by looking for alternative explanations.
  - Generic questions called "dispute handles" originally developed can be used to refute irrational beliefs in two ways. Questions about how certain we are a particular outcome will occur are referred to as **probability dispute handles**. Questions about the worst thing that could happen, and how bad that is are called **coping dispute handles**.
• **Step 4:** Replace the irrational beliefs with suitable alternatives
  – Often the replacements for automatic thoughts become evident in the course of refuting the irrational beliefs on which they are based.

**Concepts in CBT**

• **Exposure**
  – Exposure is a behavioral technique based on systematic desensitization, and arguably the most active therapeutic ingredient of cognitive behavioral therapy. It involves experiencing a feared social situation in progressively less controlled and manageable ways.
  – The first is called covert rehearsal. It involves imagining the social interaction as vividly and in as much detail as possible.
  – The second is to role play the social interaction with a therapist or fellow clients,
  – The third is to encounter the actual social situation, in-vivo.
  – Covert rehearsal and role-playing are usually done in session. In-vivo exposure is done out of session as part of homework assignments, along with reading, keeping thought records, and practicing relaxation techniques. Exposure is usually done in a progressive manner starting with the least troublesome situation from a fear and avoidance hierarchy.
  – Covert rehearsal and role-playing have the advantage of allowing the client to perform under controlled conditions, carefully set up to simulate the real-life, feared social situation.
  – Rule of thumb is to strive for a 50 percent decline in SUDS or SUDS below 30, whichever comes first, and to stop exposures when initial SUDS is below 30.

**Critical Thinking Questions**

• Why is CBT so effective?
• Why does it apply to numerous client conditions?
• Would it work with children?
• Would it work with schizophrenics or psychotics?

**LECTURE WEEK # 8**

**PERSONALITY DISORDERS**

**Definition of PD**

• Personality traits are enduring patterns of perceiving, relating to and thinking about the environment and oneself - exhibited in social and personal contexts

• It is when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress that they are disorders.
Origins of PD

• Thought to originate in childhood due to unsuccessful mastery of developmental tasks leading to anxiety and defense mechanisms
• Grouped into clusters dependent upon type
  – Cluster A, B and C

Cluster A
• Schizoid
• Schizotypal
• Paranoid
  – *All characterized by odd or eccentric behavior*

Cluster B
• Narcissistic
• Histrionic
• Anti-social
• Borderline
  – *All characterized by dramatic, emotional or erratic behavior*

Cluster C
• Dependent
• Passive-aggressive
• Avoidant
• Obsessive compulsive
  – *Characterized by anxious/fearful behavior*

Anti-social
• Pattern of disregard for the rights of others - unlawful behavior
• Aggressive and illegal acts
• Onset before 15 - with diagnosis of conduct disorder

Nursing Interventions

Anti-social PD
• Requires long term treatment in TC
• Firm limits
• Consistent to block manipulations
• Logical consequences
• Attitude of acceptance
• Identification/verbalization of feelings
• Group to offer caring/loving never received

**Continuum of PD**
• Narcissistic >> Antisocial >> Sociopathic

**Nursing Interventions**
• Narcissistic
  – Supportive confrontation
  – Limit setting
  – Realistic short term goals
  – Increase expressions of anxieties and fears
  – Cognitive restructuring around grandiosity

**General Interventions**
• Positive reinforcement
• Focus on self-esteem development
• Confrontation of irrational thinking
• Behavior modification
• Expression of feelings
• Exercise
• Chemotherapy for excessive anxiety

**Dissociative Disorders**

Web Site: http://www.issd.org/

**Definition**
- These disorders are complex and are characterized by a state of loss of awareness followed by spontaneous return
- This state is not related to an organic condition
- Often associated with childhood trauma particularly sexual abuse

**Types**
- Dissociative identity disorder (DID) - formally Multiple Personality Disorder
Characterized by the presence of two or more distinct personalities within one person - each personality at some time takes full control

DID

- "It was the horrific child abuse Sybil's psychotic mother inflicted on her, along with the failure of her father to rescue her from it that caused these personalities. Each one embodied feelings and emotions the 'real' Sybil could not cope with. The waking Sybil was deprived of all these emotions, and was therefore a rather drab figure. She was unaware of her other personas; while they were in 'control' of the body, Sybil suffered blackouts and did not remember the episodes. It was only the intervention of Dr. Cornelia Wilbur, a psychoanalyst, that alerted Sybil to them."

A depressed housewife, Eve White (Joanne Woodward), is brought by her husband (David Wayne) to consult a psychiatrist (Lee J. Cobb) because her behavior has been strange. Although she denies it, she has purchased uncharacteristically seductive clothing and has been singing and dancing in bars.

Dissociative Fugue

- In this state the person wanders for days at a time - forgetting past associations. Unlike persons with amnesia they are unaware of forgetting
- When they return to consciousness they do not remember the fugue state

Dissociative Amnesia

- Characterized by one or more episodes to memory loss related to personal information
- Total loss of memory for time periods that may last a few hours to a lifetime

Depersonalization Disorder

- Characterized by one or more episodes of feeling detached from one’s self accompanied by a temporary loss of personal reality

Interventions

- Trust is a major issue
- Safety from accidental or intentional self-harm
- Supportive environment
- Listen to each identity

Psychotherapy

- Integration of the personalities
- Identification of anxiety related to unconscious content
- Supportive insight therapy - surfacing the trauma so new coping methods can be learned
- Environmental manipulation to reduce stress
LECTURE WEEK # 9

Addictive Illnesses

Principles of Addictive Illnesses
• Progressive, chronic and fatal - characterized by relapses and remissions
• Is arrested - never cured
• A primary disease characterized by physical and psychological deficits
• Is a primary, unique and individualized disease - not result of mental illness or lack of will power
• The basic defect is biochemical
• The chief symptom is compulsion to use despite the consequences
• It is a family disease
• Severity determined by the degree of destructiveness in the person’s life

Definition of Terms
• Abstinence syndrome - manifestation of withdrawal symptoms ie. Tremor, diaphoresis, increasing B/P and pulse
• Substance abuse - self-destructive use of chemicals or food
• Substance dependence - habitual use of a substance or clear evidence that the patient has an psychological and physical need
• Tolerance - the dose required to obtain the desired effect gradually increases and there is a definite tendency on the part of the addict to increase the amount taken
• Withdrawal - comprised of physical and psychological symptoms due to abrupt cessation of the use of the substance
• Poly-substance abuse - simultaneous abuse of more than one substance
• Addiction - a state of chronic or recurrent intoxication from the use of a drug characterized by PTA:
  • Black outs - form of drug amnesia where the person will perform acts that are not remembered
  • Detoxification - process of physiological cleansing from the drug
  • Withdrawal (abstinence syndrome)
• P - psychological dependence - this implies emotional dependence, desire or compulsion to continue taking the drug
• T - tolerance - the doses required to obtain the desired effect gradually increase and there is a definite tendency on the part of the addict to increase the amount taken
• A - abstinence - physical and psychological symptoms due to cessation of the substance

Preferred Defense Structure
• Denial
• Assimilative Projection
• All or None Thinking
• Conflict Minimization/Avoidance
• Rationalization
• Self-centered/Selective attention
• Passivity vs Assertion
• Obsessional focusing
• Non-analytical thinking
• Impaired transformational relatedness

Neuron Communication
Brain Neurotransmitters and Function

• Serotonin
  – Made from amino acid tryptophan
  – Function:
    • Promotes sleep
    • Feelings of well being
    • Reduces aggression and compulsive behaviors
    • Raises the pain threshold
    • Aids function of the cardiovascular system

• Dopamine
  – Made from the amino acids phenylalanine and tyrosine
  – Functions:
    • Increases feelings of well-being
    • Increases aggression, alertness and sexual excitement
    • Reduces compulsive behavior
    • Excess may cause psychotic behavior

Dopamine Neuron And Receptor
Brain Neurotransmitters and Function

• Norepinephrine
Made from dopamine through the actions of a single enzyme: dopamine betahydroxylase

Function
• Increases feelings of well-being
• Reduces compulsive behaviors
• Excess causes anxiety, increased heart rate and blood pressure
• Can cause tremors

Brain Neurotransmitters and Function

• GABA
  Made from the amino acid glutamic acid which in turn is derived from either another amino acid called glutamine or from sugar glucose
  Functions
  • Reduces anxiety
  • Reduces compulsive behavior
  • Elevates the pain threshold
  • Reduces heart rate, blood pressure,

Brain Neurotransmitters and Function

• Endorphins
• Enkephalins
• Dynorphins
  All three of these neuropeptides are called opioid peptides because they act like natural opiates in the brain. They regulate the immune response, raise the pain threshold, stimulate well-being, regulate sexual activity, reduce compulsive behavior, promote emotional balance, enhance learning and other mental activities.

Biochemical Process of Abuse

• Phase I: Genetics
  Person born with:
  - Reduced supply of enkephalins
  - Reduced natural release of transmitters in brain reward sites
  - Reduced dopamine receptor sites
  Result: Absence of feeling of well being

• Phase II: Chemical Contact
  Contact with alcohol occurs:
  - Dopamine is released relieving the normal deficiency
There is an adequate supply of receptors for the neurotransmitters

- Result: Extreme sense of well-being. Absence of negative alcohol effects such as dizziness, nausea and loss of motor control

**Phase III: Cycle of Destruction**

- Continued use results in:
  - Decrease in enkephalins and serotonin
  - Decrease in dopamine receptors
  - Increase in enkephalin destroying enzymes
  - Change in chemical composition of enkephalins making them ineffective
  - Decrease in dopamine release

- Result: As use continues the positive effects of the chemical decreases and damage to structures of the brain increases.

**Addictive Disease Progression**

**Phase I - Contact**

- Mood changes occur
- Occasional relief use then constant relief use
- Surreptitious use
- Urgency to use develops
- Memory blackouts occur and increase with use
- Feelings of guilt begin
- Anxiety about use begins

**Addictive Disease Progression**

**Phase II - Obsession**

- Unable to discuss problem - denial begins
- Use is explained by excuses
- Unable to stop using when others quit
- Remorse and grandiose behaviors emerge
- Promises to control use are made
- Efforts to control fail
- Tries geographic escapes to control use
- Unable to discuss problem - denial begins
- Use is explained by excuses
- Unable to stop when others quit
- Remorse and grandiose behaviors emerge
Motivation decreases
Self-recrimination increases
Relationships change and terminate
Promises to control emerge
Efforts to control fail

**DSM IV - Substance Related Disorders**

**Substance Dependence**
-Maladaptive pattern of substance use leading to impairment or distress
-Three or more of these symptoms in a 12 month period
  - Tolerance
  - Withdrawal
  - Extended heavy use
  - Use is continued despite the consequences

**Substance Abuse**
-Maladaptive pattern of substance use leading to impairment or distress
-Three or more of these symptoms occur in a 12 month period
  - Failure to fulfill role obligations
  - Participates in hazardous situations
  - Substance related to legal problems
  - Use continues despite social/interpersonal problems

**Substance Intoxication**
-Reversible substance specific syndrome due to ingestion
-Significant maladaptive behavioral/psychological changes due to the effect of the substance
-Symptoms are not due to a general medical condition/not accounted for by MD

**Substance Withdrawal**
-Specific syndrome due to cessation/reduction of heavy or prolonged use
-Syndrome causes distress or impairment in social, occupational or other important areas of functioning
-Symptoms are not due to a medical condition or MD

**Treatment Models**
-Aversion therapy - extinction of alcohol craving through classical conditioning
-AA - Support group model sometimes called the “abstinence treatment model” based on spiritual precepts to promote and maintain abstinence
• Residential programs - residential treatment promoting abstinence and personal responsibility
• Therapeutic communities - development of a sense of purpose and belonging through community relationships
• Inpatient hospitalization - development of constructive coping skills through intensive therapies and support group involvement
• Partial hospitalization - intensive day treatment promoting abstinence/recovery
• Dual diagnosis - psychiatric and chemical dependency treatment to promote recovery and stabilization

Drugs and Effects on Neurotransmitters
• Alcohol - produces TIQs that mimic enkephalins, increases dopamine and inhibits GABA
• Barbiturates - stimulates GABA
• Narcotics - stimulates the release of dopamine and inhibits GABA
• Hallucinogens - modifies the actions of serotonin

Brain Reward Pathways
Drugs and Effects on Neurotransmitters
• Cannabis - uncertain but believed to affect cannabinoid receptors in the brain causing mood changes
• Cocaine - Increases dopamine

TIQ Modes of Interaction
• Mimics the functions of dopamine. TIQs may act as false neurotransmitters
• By interfering with normal dopamine metabolism, TIQs may prolong the action of dopamine
• By modulating dopamine, TIQs may provoke physical, mental and emotional changes commonly seen in alcohol dependence

Dysfunctional Family Structure
• Chief enabler - often the husband or wife
  – Attempts to protect and control the abuser
  – Is super-responsible and rescues the abuser from consequences
  – Develops a martyr role - accepting the destructive consequences of the abuser’s behavior
• Family hero - often the first born child
Family care-taker - responsible for younger children
Successful in school and later life
Works hard for approval
Attempts to stabilize family
Develops independently from the dysfunction

• Family scapegoat - typically the second child
  - Lightning rod for the family - becomes focus of family anger
  - Gets into trouble - often uses chemicals
  - Inappropriate peer groups
  - Defiant - often acts out sexually

• Family lost child - often the third or middle child
  - Less angry - more lonely
  - Sometimes overweight or has health problems
  - Shy, aloof or withdrawn
  - Quiet and often super-intellectual

• Family mascot - often the baby - the last child
  - Teases and clowns
  - An under-achiever
  - Creates humor in the family
  - Tends to develop phobias
  - Family showman

Johnson Model of Intervention

• Based on the principle of “bringing the bottom up”
• Performed with caring and compassion
• Results in treatment seeking within 1 year of the intervention

Nursing Assessment-Intervention With the Detoxifying Patient

Drugs In Order of Detox Acuity
- Alcohol
- Benzodiazepines (Valium)
- Cocaine
- PCP
- LSD
- Heroin (narcotics)
- Marijuana
Alcohol

- DTs have a 10-15% mortality rate
  - Escalating pulse and blood pressure
  - Diaphoresis
  - Tremor - gross motor and fine motor
  - Illusions and hallucinations
  - Seizures
  - If a patient is allowed to progress to DTs it is a failure of nursing care - POOR

NURSING CARE

Alcohol

- Expect withdrawal symptoms 6-8 hours after the last drink
  - Monitor pulse and B/P. Increasing pulse best indicator of impending DTs - Medicate with Librium or Valium when pulse is 90 or above.
  - Usually ordered q 4 hours and prn based on withdrawal (abstinence) symptoms

Alcoholic Encephalopathy

- Wernicke’s encephalopathy due to chronic ETOH – ataxia, nystagmus, confusion
  - May clear in a few days or weeks – respond rapidly to parenteral doses of thiamine
  - B vitamins important if treatment of withdrawal from ETOH

Critical Abstinence By Drug Type

- Cocaine - involves deep depression and high craving - drug seeking behavior
- Valium - severe detox risk with possibility of seizure - fractionalized decreasing doses of drug used
- Heroin - not life threatening as with alcohol or valium but uncomfortable. Treated with clonidine for symptom relief
- Methamphetamine – Tachycardia, possible seizures, depression, anxiety; Valium for tachycardia and seizure risk. Thorazine for physiological effects. High relapse due to drug craving.
  - Abuse leads to high risk for stroke and death
- PCP - potential for violence due to excessive response to stimulii. Neuroleptic used to reduce aggression (Haldol).
- LSD - provide safety - monitoring due to possibility of “bad trip”.
- Marijuana - stored in fat so will take time to detox based on fat; see Text pg. 339 for dangers of cannabis
Detoxification Protocols
- **Cocaine/Crack** - may treat the depression with mild anti-depressant - monitor for suicidal ideation
- **Valium** - monitor closely for tremor, increasing pulse - high seizure risk - treat with fractionalized decreasing doses of Valium
- **Heroin** - addicted to the needle and the experience of the drug. Withdraw on clonidine - anti-hypertensive drug. Take B/P if orthostatic drop of 10mm HG or more d/c. Muscle aches, runny nose, yawns and chills.
- **Methadone and Buprenorphine**
  - Methadone synthetic narcotic
  - Is addictive but alleviates withdrawal
- **Buprenorphine**
  - Opioid agonist and analgesic - alleviates withdrawals and has low abuse potential
- **PCP** - Valium for muscle spasms, seizures, agitation; neuroleptic (Risperidone, Haldol) but very dangerous because of possible drug interactions - cardiac arrests
- **LSD** - environmental interventions - provide safety
- **Amphetamines** - environmental - somnambulistic - will need to sleep
- **Marijuana** - purge through orange juice; exercise to remove from fat

Psychological Detoxification Protocols
- Prevent withdrawal symptoms but do not foster drug seeking behaviors
- Sleep, nutrition, exercise and the treatment program are all part of the recovery from addictions
- Flight to health concept
  - Interventions
  - Monitor closely for abstinence - indicate hope for recovery and how much better the patient will feel.
  - Confront denial and “addictive” thinking
  - Provide support and set limits on manipulative behavior
  - Euphoric recall: Shift focus on issues of recovery rather than memories of use

Other Drug Protocols
- **Naloxone** - narcan given in ER for drug overdoses with narcotics (opioids) to prevent CNS depression. It blocks the neuro-receptor effects of opioids. Monitor air way and vitals q 15
- **Antabuse** - used to maintain abstinence - causes hypotensive crisis when ETOH is ingested with the drug.

Eating Disorders
Presentation Overview
- Principles of eating disorders
• Anorexia Nervosa
• Bulimia
• Non-Compensatory Bulimia
• General symptoms

Nursing interventions
• Abstinence
  – *Interruption of the dysfunctional eating patterns*
  – Incorporation of new and more functional eating behaviors
  – Incorporation of new and more functional methods of coping with feelings
  – Disintegration of the emotional barriers that create isolation, loneliness and evoke the sense of separation
  – Disintegration of denial patterns
  – Identification of and improvement in disruptive family and social relationships
  – Establishment of new and more effective communication patterns that will improve interpersonal relationships
  – Involvement in Overeaters Anonymous
  – Instruction in relapse prevention and return to normalized eating and healthy behavior patterns

Anorexia Nervosa - Definition
• Self-starvation, predicated by an over-whelming fear of fatness
  – 95% female
  – Onset usually at puberty

Anorexia Nervosa - Patterns
• Weight loss due to severe fasting
• Often obsessed with exercise
• Uses food as a control issue with the family
• Denies hunger pains
• Severe, unrelenting weight loss 25-50% of body weight

Anorexia Nervosa
• Intense fear of becoming obese - does not diminish with weight loss
• Disturbance of body image
• Weight loss of at least 25% of original body weight or if under 18 weight loss of original body weight plus projected weight gain from growth charts tallying to 25%
• Refusal to maintain body weight over a minimal normal weight for age and height
• No known physical illness cause that would account for the weight loss
**Anorexia Nervosa - Physical Problems**

- Hypothermia
- Electrolyte imbalance
- Cardiac distress
- Hypotension
- Susceptibility to infectious diseases
- Severe fatigue
- Death occurs from starvation - 20% mortality rate
- Avoids adult responsibilities - perpetuates child dependency
- Menstrual cycle absent - amenorrhea
- Denies hunger
- Adamantly emphasizes perception of being overweight

**Non-Compensatory Bulimia - Definition**

- Weight above the standard weight and height tables
- Major medical complications attributable to obesity. At least one of the following:
  - Adult onset of diabetes - requiring oral or injectable insulin
  - Hypertension requiring treatment with anti-hypertensives
  - Hypercholesterlimia or hypertriglyceridemia
  - Angina, coronary artery disease, history of MI
  - History of large vessel atherosclerosis - renal, leg claudication or stroke
  - Gallbladder disease
- True carbohydrate craving
- Stealing food, hiding food and chronically lying about food consumption
- Preparing food for others and consuming it all
- Compulsive cooking or working in the food industry
- Consuming greater than 4,000 calories at a single sitting
- Obsessive diet or weight fluctuations of greater than 30 pounds

**Bulimia Nervosa - Definition**

- Binge eating, followed by purging, using vomiting, laxatives or diuretics
  - Majority are female

  - Onset usually during adolescence - can continue indefinitely

**Bulimia Nervosa - Patterns**

- Ingests large quantities of food (average 4,800 calories) in a short period of time then purges
- Binges in secret
• Binging and purging become the ideal diet

**Bulimia Nervosa**

• Recurrent episodes of binge eating - rapid consumption of food usually in less than two hours
• At least three of the following:
  • Consumption of high-caloric, easily ingested food during a binge
  • Inconspicuous eating during a binge

• At least three of the following:
  – Termination of such eating episodes by abdominal pain, sleep, social interruption or self-induced vomiting
  – Repeated attempts to lose weight by dieting, vomiting, cathartics or diuretics
  – Frequent weight fluctuations greater than 10 pounds due to binging/purging
  – Awareness that eating pattern is abnormal and fear of not being able to stop voluntarily
  – Depressed mood and self-depracating thoughts following eating binges
  – Episodes are not due to Anorexia Nervosa or any known physical disorder

**Bulimia Nervosa - Physical Problems**

– Electrolyte imbalance
– Erosion of the esophagus lining
– Kidney failure
– Abnormal liver function
– Stomach rupture
– Cardiac Distress
– Tooth and gum damage
– Calluses on back of fingers
– Menstrual cycle may be present, irregular or absent
– Frequent cross addiction with other drugs/laxatives or diuretics
– Death is usually due to electrolyte imbalance or cardiac arrest.
– Use of ipecac is fatal over prolonged period

**Eating Disorders - Physical Assessment**

• Skin/Hair
• Salivary glands
• Bowels
• Edema
• Abdominal area
• Teeth and gums
• Menstrual cycle
Milieu Management

• Group therapy after eating
• Back turned to scale – no focus on weight
• Accompany to the bathroom
• Gentle eating
• Taking control of eating

LECTURE WEEK # 10

Domestic Violence

The problem

❖ In the US a woman is beaten every 15 seconds
❖ At least 30% of female trauma patients (excluding MVA) have been victims of domestic violence
❖ Medical costs exceed 44 million
❖ 3 million children witness acts of violence every year
❖ Many of these children learn that violent behavior is an acceptable way to express anger, frustration or the will to control
❖ Violence in the family of origin is correlated with victimization as an adult
❖ Cross-generation transmission may be as high as 30-40%
❖ 3-4 children out of every 10 who witness violence in their families are at increased risk for becoming involved in relationship violence in adulthood

Manifestation of Domestic Violence - Power and Control

❖ Psychological Abuse

❖ Physical Abuse

❖ Threats of financial, psychological or emotional harm

❖ Attempts to frighten and physical assaults

❖ Using privilege

❖ Economic abuse

❖ Treating her like a servant - Master of the Castle; rigid roles

❖ Creating financial dependence; taking her money; making her ask for everything

❖ Emotional abuse

❖ Sexual abuse

❖ Intentional minimization, humiliation
• Forcing sex; physical attacks
• Intimidation
• Isolation
• Looks, actions that threaten, destroying her property, displaying weapons
• Controlling who she sees, limiting what she does - where she goes

**Connections**
• 25%-50% of the men who commit acts of domestic violence also have substance abuse problems
• 80% of child abuse cases are associated with alcohol and drugs
• Women who abuse alcohol and other drugs are more likely to become victims of domestic violence
• Childhood physical abuse is associated with later substance abuse by youth
• Alcoholic women are more likely to report childhood physical and emotional abuse

**Entering the system**
• When a patient presents for substance abuse treatment and informs the staff she is a victim of domestic violence - treatment providers should focus on:

**Crisis Intervention**
• Ensuring the patient’s safety
• Validating and believing her
• Identifying options
• Assessing the degree of danger is tantamount:

• Denial
• Minimization
• Self-blame
• Rationalization

**Treatment Focus**
• Shift of responsibility to the abuser
• Improving decision making skills
• Post-traumatic stress
• Medications
• Social functioning
• Parenting
• Financial and legal concerns
• Relapse prevention
**Issues for Children**

- Tend to display strong feelings of grief, loss, abandonment, betrayal, rage and guilt.
- Older children feel shame
- Signs of serious problems

**Signs of serious problems**

- Emotional lability
- Aggression
- Destructive behavior - toward others, objects or animals, self-mutilation
- Inappropriate sexual behavior
- Regressive behaviors - bed-wetting, thumb-sucking, rocking, not speaking, security objects

**Role of treatment providers**

- Help the mother identify and coordinate various services she needs
- Support her efforts to participate in and take advantage of services
- Listen empathetically as she voices frustration
- Clarify an action plan
- Serve as an intermediary and advocate

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**PSYCH NURSING CARE OF CHILDREN**

**Introduction**

- CHILD LIFE STRESS SCALES
- HEALTHY CHILD PARENTAL RESPONSE MODEL
- ASSESSMENT OF THE CHILD
- CHILDREN WITH SEVERE EGO DEFICITS
- DRUGS USED IN TREATMENT
- NURSING CARE

**Overview of Course**

- Stresses unique to the child
- Assessment of the child
- Severe ego deficit behaviors
- Adaptive parental responses
- Drug treatment for child disorders
- Key nursing interventions with the child

**STRESSES PRESCHOOL**

- Beginning pre-school 42
- Parental arguments 39
● Birth of another child 50
● Mother working outside home 47
● Change to new pre-school 33
● Serious illness/hospitalization 59
● Divorce of parents 78

STRESSES SCHOOL - AGE
● Death of parent 109
● Death of brother/sister 86
● Divorce of parents 73
● Hospitalization of parent 52
● Re-marriage 53
● Birth of sibling 50
● New problems between parents 44

PARENTAL RESPONSE MODEL
● Moderate and flexible
● Consistent in conduct
● Provides emotional reassurance
● Promotes peer play
● Sets reasonable limits/controls
● Shows pleasure and praise
● Paces self to child’s learning capabilities

PARENTAL PATHOLOGY
● Severely coercive, threatening and punitive
● Critical and rejective
● Over identifies with child
● Substitutes child for spouse
● Deprives stimulation, freedoms, pleasure
● Extreme anger
● Child assault - brutality

CHILD ASSESSMENT
● Appearance - describe the physical size, manner, dress, posture, handicaps, non-verbal behavior
● Defense Mechanisms - describe the child’s major defenses used to cope with anxiety
● Neuromuscular - describe the child’s ability to move in a coordinated manner; use fine motor skill
● Thought processes - describe the child’s thoughts; are they logical, cohesive, coherent?
  – Flight of ideas, loose associations, primary process thoughts?
  – Hallucinations or delusions
— **Body image distortions?**
- Fantasy - describe the child’s ability to fantasize and know the limits of fantasy
- Concept of Self - describe the child’s level of self-concept, self-image and self-ideal
- Orientation - describe the child’s concept of time, ability to perceive who and where s/he is
- Superego - describe the child’s value system, ability to discern right from wrong and ability to respond in a new setting
- Estimated IQ - describe the child’s general fund of information and ability to perform age appropriate tasks
- Interpersonal Relationships - how the child relates to peers, adults
- Activities - type of activity the child engages in, energy level, ability to engage in solitary play
- Personal/Family History - precipitating problem, history of symptoms, growth and development and school adjustment

**ASSESSING CHILD’S RELATIONSHIPS**
- Are relationships formed with those nearest the child in age
  - With the same or opposite sex
- What is the child’s position in the power structure of the group
- How good are the child’s social skills
  - In approaching other children
  - Have a best friend

**CHILD EGO DEFICITS**
- Failure of normal repression
  - Sexual acting out
- Primitive defense mechanisms
  - Denial/projection
- Failed ego synthesis
  - Impaired reality testing
- Lack of basic trust
  - Withdrawn/isolating
- Impaired object relationships
  - Inability to establish close relationships
- Persistent narcissism
  - Lack of insight into own problems
- Primary process thinking
  - Hallucinations
- Failure to sublimate impulses
  - Aggressive/destructive
DISORDERS AND DRUG CLASSES

- **Attention Deficit-Hyperactivity**
  - Inattention to surrounding, hyperactivity and impulsiveness
  - Psychostimulants - to reduce hyperactivity such as Ritalin and Adderal

- **Conduct disorder** (Childhood onset before age 10) – little empathy, misinterpret intentions of others as hostile & threatening and respond with aggression
  - More likely to develop antisocial personality disorders than in adolescent onset
  - Antipsychotics/Stimulants

- **Functional enuresis**
  - Antidepressants (Imipramine)

- **Affective disorders**
  - Antidepressants

- **Autism** – impaired social interaction and communication
  - Clinical trials with Strattera (norepinephrine reuptake inhibitor); Zyprexa, Abilify, Ritalin, Prozac and Risperdal

- **Asperger’s Disorder** –
  - Some features of autism but not all
  - Problems with social interactions
  - Restricted and repetitive behaviors
  - No delay in cognitive development, age-appropriate self help skills and adaptive skills
  - Psychotropic drugs for anxiety and depression

- **Separation anxiety disorder**
  - Antidepressants (Imipramine)

- **Anxiety, impulse problems**
  - Antihistamines (Benadryl)

- **Schizophrenic disorders**
  - Antipsychotics

- **Pervasive developmental disorders**
  - Antipsychotics

PROGRAM STRUCTURE

- Family therapy
- Group therapy
- Play therapy
- Activities therapy
NURS 4564.001 Fall 2011

- Individual therapy
- Psychopharmacology
- Milieu therapy
- Parent education

NURSING INTERVENTIONS
- To manage tension
  - Accept delays
  - Build secure relationships
- To strengthen attachment
  - Increase parental responsiveness
  - Be available and constant
- To strengthen autonomy
  - Encourage adaptability
- To improve peer relationships
  - Facilitate emotional expression
  - Use individual, peer, play therapy
- To strengthen interpersonal relationships
  - Use supportive peer culture
- To enhance social skills
  - Foster play and peer friendships

SUMMARY
- Psychopharmacology
- Assessment
- Relationships
- Responsiveness
- Structure
- Expressive modalities
- Reliability
- Fostering strengths

ADOLESCENT PSYCH

COURSE OVERVIEW
- Cognitive Structure
- Attitudinal Structure
- Defenses
- Inpatient Treatment
- Nursing Interventions
COGNITIVE STRUCTURE
◆ Characteristics of Adolescent Cognition
– Black/White
– Always/Never
– Positive/Negative
– Love/Hate
– Me/Mine
– Right/Wrong
– Fair/Unfair

BLACK/WHITE THINKING
◆ Polarized thinking referred to as dichotomous or all or none thinking
◆ Perceives events in extremes
◆ Places two parents in role of “good” guy and “bad” guy
◆ Place peers as freaks, geeks, ropers, preps
◆ Uses words like “always, never, everybody”

ALWAYS/NEVER THINKING
◆ A form of over-generalized thinking
◆ Incorrectly makes generalizations based on one piece of information
◆ “Everybody at school uses drugs,” “You never let me do what everyone else’s parents do.”

POSITIVE/NEGATIVE THINKING
◆ A form of filtering - this occurs when the person selects only certain aspects of experience to focus on and blows them out of proportion
– “You’re always mean to me - you never let me have anything I want.”

LOVE/HATE THINKING
◆ A form of thinking characterized by emotional reasoning
◆ This occurs when the person believes his/her own feelings
◆ The mature person analyzes and sorts feelings - the adolescent acts immediately on feelings believing they are reality

ME/MINE THINKING
◆ Ego centricity is a thinking disturbance that is grossly apparent in adolescents
◆ This distortion refers to an individual’s inability to focus on anyone’s experience but his/her own
◆ The adolescent believes that his/her feelings, thoughts, problems are the only things that matter or exist
EGO CENTRIC THOUGHT
◆ A variation of ego centric thought is the “personal fable” in which the adolescent concludes that negative consequences happen to others - such as car wrecks, arrests, unwanted pregnancies
◆ Due to ego centrism adolescents fail to see the effect their actions have on the feelings of others

RIGHT/WRONG
◆ Pseudo-intellectualisms - the adolescent goes about deciding what is right and wrong for society, parents and the world
◆ The adolescent develops a variety of “shoulds”
◆ The adolescent becomes grandiose and feels superior to those around him/her

FAIR/UNFAIR THINKING
◆ The adolescent interprets the actions of others, especially authority figures, in terms of whether they are fair or just
◆ What is fair to the adolescent is usually more in line with what they want

TREATMENT OF DISTORTIONS
◆ In treatment these distortions are addressed directly
◆ A positive, open, caring, firm and consistent environment augments the development of rational thinking

ATTITUDINAL STRUCTURE
◆ Hedonism - the attitude is: “If it feels good, do it.” Related to narcissism
◆ Promiscuity, lying, drug abuse, stealing, running away are all out growths of an hedonistic attitude.
◆ Naivete - related to hedonism and ego centricty - “Things will always turn out for the best”
◆ This attitude is related to the “personal fable”

DEFENSES
◆ Defenses are utilized by the adolescent to minimize feelings of inferiority, inadequacy or guilt
◆ In moderation defenses serve to protect but used excessively they distort feelings and affect behavior
◆ Rationalization - the adolescent minimizes or explains the severity of the problem
◆ Externalization - the adolescent projects the responsibility or blame for his behavior onto someone or something else
  - *Self-pity and victimization are typical emotional companions to the externalization process*
ACTING OUT
◆ The adolescent acts impulsively in an attempt to avoid or escape unpleasant feelings
   – Tantrums, suicide attempts, running away, fighting, yelling and alcohol and drug abuse are all forms of acting out

DEFENSE MECHANISMS
◆ The utilization of defense mechanisms prevents the adolescent from experiencing reality - a reality that includes feelings of hurt, inadequacy, fear, failure and anger.
◆ If reality is constantly distorted the adolescent never learns to cope successfully with, master, accept and understand feelings and behaviors

INPATIENT TREATMENT
◆ Structured - intensive milieu
◆ Clearly defined limits
◆ Level system
◆ Family therapy
◆ Group therapy
◆ Didactic therapy and education
◆ Experiential therapy

NURSING INTERVENTIONS
◆ Empathy and respect
◆ Clear and consistent limits
◆ Numerous 1:1 interactions
◆ Confrontation of distortion
◆ Group/peer work on issues
◆ Careful modeling of behavior
◆ Teaching alternative behaviors

LECTURE WEEK # 11

PSYCHIATRIC CARE OF THE ELDERLY

Introduction
◆ Cognitive Deficits and the Elderly
   – Delirium
   – Dementia
   – Alzheimers
◆ Nursing Interventions in Delirium and Dementias
◆ Treatment Program Interventions
Delirium
◆ Disorientation for TPP&P
◆ Usually with illusions, hallucinations
◆ Causes
  – Alcohol or other drug induced
  – Endocrine imbalance
  – Hypoxia
  – Viral or bacterial

Dementia
◆ Insidious development of memory and intellectual deficits
◆ Disorientation
◆ Alterations in mood

Alzheimers
◆ B-Amyloid neuritic plaques
◆ Acetyl choline deficits
◆ Staged according to cognitive deficits that affect behavior

Nursing Interventions in Delirium and Dementias
◆ Physiological and safety interventions
  – Naps, nutrition, exercise, social engagement
◆ Reality orientation
◆ Regular schedule
◆ Distraction
◆ Social involvement

Treatment Program Interventions
◆ Life review
◆ Reminiscence groups
◆ Reality orientation
◆ Validation therapy
◆ Cognitive training
◆ Therapeutic “fibbing”
◆ Family education and support

NURSING FOCUS
◆ Foster as much independence as possible
◆ Assess disorientation - do not just assume the patient is confused
◆ Encourage expression of grief, losses
◆ Medications - no barbiturates due to delirium and paradoxical excitement
What would the nurse do if the patient is found up wandering the halls during the night?

If a patient is aggressive and strikes out how should the nurse protect other patients yet still permit patient interaction?

When the elderly are in a hostile or threatening environment what type of thinking do they display?

An elderly female in the nursing home is on numerous medications. She demonstrates illusions and hallucinations - what does the nurse suspect first?

Summary

Delirium is an acute organic brain syndrome
Dementias/Alzheimers more chronic progressive
Mental status for OBS shows impairment of recent memory

Family Therapy

Presentation Overview

• Historical - Origins of Family Therapy
• Growth of Family Therapy - 1950 to present
• Contemporary Theories and Practices
  – Psychodynamic
  – Experiential/Humanistic
  – Bowen’s
  – Structural
  – Strategic

Origins and Historical Perspective

• Psychoanalysis
• General Systems Theory
• Studies of Schizophrenia and the family
• Marital counseling and child guidance
• Group therapy

Growth of Family Therapy 1950 - present

• 1950s - From family research to family therapy
• 1960s - The rush to practice
• 1970s - Innovative techniques and self-examination
• 1980s - Growth, professionalization and a new epistemology
• 1990s - Integration and eclecticism

**Psychodynamic - Theory and Practice**
• Psychodynamic process
• Object relations theory
• Object relations therapy
• Contextual therapy

**Experiential/Humanistic Approaches to Theory**
• The experiential model
• The humanistic model

**Bowen’s Approach to Theory and Practice**
• Family systems theory
• Bowen’s Eight interlocking theoretical concepts
  – *Differentiation of self*
  – *Triangles*
  – *Nuclear family emotional system*
  – *Family projection process*
  – *Emotional cutoff*
  – *Multigenerational transmission process*
  – *Sibling position*
  – *Societal regression*
• Evaluation interview
• Genogram
• Family intervention techniques

**Structural Approach to Theory and Practice**
• Structural family theory
  – *Family structure*
  – *Family subsystems*
  – *Boundary permeability*
  – *Alignments, power and coalitions*
  – *Family dysfunction*

**Structural Family Therapy**
• Family mapping
• General therapeutic considerations
• Structural intervention techniques
• Therapeutic goals

**Communication-Strategic Approaches**

• MRI interactional family therapy
  – Developing a communication paradigm
  – Behavior as communication
  – Report and command functions
  – Symmetrical and complementary relationships
  – Therapeutic assumptions
  – Therapeutic double-bind

**Strategic Family Therapy**

• The meaning of symbols
• Developing therapeutic strategies
• The initial interview
• The use of directives
• Pretend techniques and family metaphors
Fall Semester 2011

Clinical laboratory: Thursday and Friday: 7 AM – 3:30 PM

CLINICAL FACULTY:

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Credit Hours: 2 semester credit hours
Co-requisite: NURS 4564 Lecture 3 semester credit hours (5 semester credit hours)

Course Description: Application of the nursing process to promote, maintain or restore emotional health to individuals, families and groups. During the clinical experience, students will demonstrate theory-based practice and collaborate with interdisciplinary team members.

Clinical Course Objectives: At the completion of the clinical course, the student will be able to:
1-0 Integrate the process of self-examination into the psychiatric nursing experience.
1-1 Analyze subjective feeling states and reactions in response to psychiatric nursing experience.
1-2 Verbalize feelings aroused by clinical experiences.
1-3 Explain the relationship between self-diagnosis and the therapeutic nurse-patient relationship.
1-4 Explain how behavior is linked to feelings.

2-0 Apply the nursing process to situations involving clients with psychiatric and chemical dependency diagnoses.
2-1 Assess subjective and objective data related to the client’s mental/substance abuse disorder.
2-2 Formulate psychiatric and substance abuse nursing diagnoses for inpatient and outpatient populations.
2-3 Plan and implement nursing interventions for clients with mental and substance abuse disorders.
2-4 Evaluate client responses to nursing actions.
2-5 Demonstrate safe and effective practice.

3-0 Demonstrate the components of the empathic-caring relationship.
3-1 Create effective caring behaviors to develop, maintain and terminate the empathic-caring relationship.
3-2 Implement psychiatric nursing interventions within the nurse-patient relationship.
3-3 Demonstrate increasing competency in using therapeutic communication skills with psychiatric/substance abusing clients.

4-0 Incorporate the teaching-learning process into the plan of care.
4-1 Formulate learning objectives based upon an assessment of an individual or group’s needs and readiness to learn.
4-2 Prepare a teaching plan specific to the needs and readiness of the target learner/s.
4-3 Implement the teaching plan following objectives and evaluate.

5-0 Collaborate with other health care providers in the care of individuals or groups.
5-1 Participate with other team members in the formulations of nursing care plans for individuals
5-2 Participate in group, unit and program activities.
5-3 Articulate significant client information to team members.
5-4 Utilize the resources of other disciplines to solve problems related to specific clients.
5-5 Deliver safe and consistent nursing care to individual clients in a variety of settings.
Analyze clinical therapeutic modalities and their effectiveness with clients.
Continually assess the therapeutic milieu for effectiveness and safety.
Interpret the roles of the multi-disciplinary team and describe the teams functioning.

Accept responsibility for own learning.
Select independent learning experiences related to clinical assignments.
Evaluate own progress against clinical objectives and expectations.
Evaluate progress against observed role models in the clinical settings.
Attend clinical assignments on time, appropriately dressed and following specific clinical guidelines.
Demonstrate ethical behavior and maintain patient rights and confidentiality.
Demonstrate respect for clients from diverse cultures and economic status.

Clinical Activities: Students are required to attend 16 hours of clinical each week and two community support groups to obtain the 90 clinical hours. Students will follow the clinical rotation assignment and the specific clinical objectives identified for each area. Required clinical activities include:

1. Timely attendance at all clinical placements. LATE arrival to the clinical setting is considered non-professional behavior.
2. Attendance at two self-selected community support groups documented in the Clinical Journal by responding to Support Group Clinical Objectives and completed during the clinical rotation period. These support groups must comply with module objectives.
3. Weekly documentation of specific clinical objectives in Clinical Journal with timely submission of log to clinical faculty (see specific objectives for each placement site).
5. Implementation and documentation of a group or individual teaching plan utilizing Teaching/Learning Plan and criteria.
6. Completion of a comprehensive nursing care plan on a selected psychiatric patient.
7. Clinical performance in accordance with clinical objectives and outcome behaviors.
8. Completion of outplacement clinical objectives.
9. Completion of a satisfactory Process Recording.
Patient Rights and Safety

The nature of clinical nursing courses is such that students are involved in the direct delivery of patient care services. The primary purpose of any course is to provide education for students. However, when direct patient care is involved in the learning experience, the safety and well being of the patient are of paramount concern and take precedence over all other factors. Clinical courses are structured so that as students progress through the program they are expected to demonstrate increasing independence, critical thinking and competence in providing nursing care.

Students are expected to demonstrate achievement of the clinical objectives by the end of the clinical course. If the student is deemed unsafe or unable to provide safe nursing care, in the instructor’s professional judgment, and if the deficit is such that it cannot be remedied within the clinical setting, the student will be removed and will receive an “F” in the course.

Clinical Warning and Failure

Clinical attendance is mandatory and professional behavior is expected. Loss of time in the clinical setting for whatever reason could place a student in jeopardy of not meeting the course objectives. There are several infractions that might lead to a student being given a clinical warning for the day include but are not limited to:
- Absences
- Tardiness
- Illness
- Violation of dress code (either in hospital or during data collection)
- Incomplete health immunization records
- Expired CPR certification
- Failure to turn in care plan when due
- Incomplete hospital orientation on WebCT
- Violation of Patient Mental Health rights
- Chewing gum in the clinical setting

If an absence from the clinical site is absolutely necessary, the student must notify his/her clinical instructor at least one hour before the clinical day begins. Accumulating 2 warnings in a 90 hour clinical course or 3 warnings in a 135 hour clinical course will lead to failure of the clinical rotation and therefore, failure of the entire course. Other offenses, depending on severity, may lead to immediate failure of the course include but are not limited to:
- No call, no show for clinical day
- Unsafe or unprofessional practices or behaviors
- HIPAA violations
- Inability to pass required clinical assignments
• Falsification of records.

**Required Textbooks:**

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**Clinical Evaluation Criteria:**
- Clinical Performance Evaluation (Professionalism) 60%
- Clinical journal 10%
- Clinical site objectives 10%
- Clinical outcome objectives
- Clinical self/professor evaluation
- Specific clinical site objectives 10%
- Teaching/Learning plan 10%
- Nursing Care Plan 20%

100%
PSYCHIATRIC NURSING ACUTE INPATIENT
CLINICAL OBJECTIVES

The student will select a patient with the assistance and direction of the staff. For the specific patient, the student will:

1. Establish a one to one relationship.

2. Implement the initial, working and closing phase of the nurse-patient relationship.

3. Utilize appropriate therapeutic communication techniques.

4. Assess current health/illness status of the patient based on identified psychosocial and physical parameters utilizing the A&M Model of Nursing.

5. Appraise the patient’s/family’s subjective and objective data manifested in identified health problems.
6. Analyze the major stressors/stimuli and other influences that result in maladaptive behavior.

7. Provide nursing care to the patient utilizing psychiatric nursing interventions.

8. Deliver necessary teaching to the patient in order to meet documented health problems.

9. Assist with therapeutic interventions and identify patient outcomes.

10. Complete all clinical teaching/learning activities.

**LEARNING ACTIVITIES**

1. Meet with the faculty for regularly scheduled consultation conferences related to the patient.

2. Complete one Comprehensive Care Plan as outlined in the syllabus.

3. Accompany the patient to program activities as permitted.

4. Co-teach or teach one group utilizing A&M teaching plan and based on an assessment of the patient's needs. This project **MUST** first be approved by the faculty and charge nurse of the unit or facility.

5. Record one process interaction with a patient in the clinical journal using the prototype included in this syllabus (see Process Recording form). Select an interaction that you found challenging to manage.

6. Document two patient incidents in the clinical journal using the PIE (Problem, Intervention and Evaluation format). In the intervention identify the specific psychiatric nursing intervention utilized.

7. Identify two ethical concepts from Appendix B (p. 22) that apply to three patient care situations observed in the clinical setting. Describe how these ethical concepts relate, and the significance to nursing care.
MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM

CLINICAL OBJECTIVES

1. Identify the structure and function of the therapeutic program for these patients.

2. Discuss three elements of group process/group therapy observed during the program and relate to group therapy as it is discussed in your text.
3. Describe the various roles of the multi-disciplinary team members in the partial hospital program.

4. Discriminate between the higher functioning and lower functioning groups that are provided to the patients. Discuss in what way these group processes differ.

5. Contrast the role of the nurse in the partial hospital program to the nurse’s role in the inpatient setting.

6. Describe the DSM IV-TR diagnostic categories for two patients observed in the day treatment program and apply theoretical concepts to the following: (1) medications needed for this diagnosis, (2) social support required, (3) nursing interventions utilized.

7. Identify two medications patient’s are taking and discuss function, side effects, nursing interventions and educational needs.

8. Summarize the goals of the day treatment program and relate these goals to the functioning of two clients that you have observed.

INPATIENT GERO-PSYCHIATRIC PROGRAM

CLINICAL OBJECTIVES
1. Collaborate with the nursing staff in providing psychosocial care to the geropsychiatric patient.

2. In collaboration with the Nurse Manager, develop and deliver a mini-group for a pre-selected group of patients.

3. Identify the psychosocial issues crucial to the functioning of these patients.

4. Discuss the physical and psychosocial interventions utilized to provide comprehensive care of the elderly psychiatric patient.

5. Evaluate the impact of the activities therapy on the elderly psychiatric patient.

6. Relate the importance of family (or absence of family) and other aspects of psychosocial support in the care of the elderly psychiatric patient.

7. Report five communication strategies important in relating to the unique needs of these patients.

8. Discuss your personal values/philosophy in the care of these patients.

9. Analyze the role of the nurse in the care of the geropsychiatric patient.

10. Discuss one of the most common DSM IV-TR diagnostic categories identified in these patients.

11. Analyze the effect of Reminiscence Therapy with this group of patients.

   How does this form of therapy relate to reality orientation?

12. Select three medications prescribed for these patients and identify at least two nursing care concerns for each category of medication.
AAdi Home Health
Psychiatric Home Health Program

At the end of the clinical experience the student will be able to:

1. Discuss the role of the psychiatric home health nurse and relate to the counseling role of the nurse.

2. Delineate the elements of the nursing process implemented in the care of the psychiatric patient by the home health nurse:
   
   Assessment of the patient in the home.

   Care planning for the patient in the home.

   Involvement of the care giver and/or family members in the plan of care developed by the psychiatric home health nurse.

3. Discuss the psychotropic medications utilized by the patient and the role of the psychiatric home health nurse in the education and monitoring of the patient’s medications.

4. Identify the various roles of other team members and the significance of these roles to patient treatment in the home.

5. Describe the case management role of the psychiatric home health nurse in the care of the psychiatric patient.

6. Discuss the process of continuing care of the psychiatric patient in the home.
CHEMICAL DEPENDENCY INTENSIVE
IN OR OUT-PATIENT PROGRAM
CLINICAL OBJECTIVES

1. Describe the structure of the intensive out-patient program and relate its significance to the treatment of chemically dependent patients.

2. Discuss the role of the nurse in the assessment of the patients in this program.

3. Relate the significance of the After-care Program to the recovery of the substance abusing patient.

4. Discuss the category of dual diagnosis and provide examples of these diagnoses.

   Discriminate between the treatment strategies for these patients in comparison to patients with a single diagnosis.

5. Discuss the concepts of relapse and remission relative to the disease of chemical dependency.

6. Discuss the continuum of care for substance abusing patients.
SOUTH TEXAS SUBSTANCE ABUSE AND RECOVERY SERVICES (STSARS)
Clinical Objectives

At the end of the clinical experience the student will be able to:

1. Discuss the role of substance counselors/therapists and relate to the counseling role of the nurse.

2. Delineate the structure of an outpatient treatment program for substance abusers.
   
   What are significant components of the program?
   
   How does the program relate to the theories of addictions/substance abuse?
   
   What is the relationship between program elements and the 12-Step Program of AA/NA?

3. Describe the functions, protocols and significance of methadone treatment for opiate addiction.

4. Identify the various roles of team members and the significance of these roles to client treatment.
5. Select **two program** activities that you observed and delineate **three important elements** about substance abuse treatment that you learned from these two activities.

6. Discuss the stressors that substance abusers face in the process of recovery.

7. Identify two principles of addiction/addictive behaviors that you would use in teaching clients about substance abuse based on this clinical experience.

8. List three attitudes or beliefs you held about substance abusers that have been changed or modified by this clinical experience.

9. In collaboration with the program director, develop and deliver an educational presentation for the clients in the program.

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**RAINBOW HOUSE/RUSTIC HOUSE
CLINICAL OBJECTIVES**

1. Collaborate with staff on the provision of a mini-health teaching or experiential group project while at the facility.

2. Participate, as appropriate, in the serving of meals at Loaves and Fishes.

3. Assist in the Gabbard Health Clinic, as appropriate.

4. Discuss three aspects (psychobiological, social, economic) that affect the client’s ability to seek treatment for mental illness.

5. List, in order of priority, the needs of this unique population.
7. Evaluate the Life-skills most needed for this group of clients and indicate how these programs assist in the development of such skills.

8. Relate three therapeutic communication skills most commonly used in relating to these clients.

9. Analyze the statutory regulations of the Texas Mental Health Code and relate two of these regulations to this client group.

Charlie’s Place
Substance Abuse Recovery Program

At the end of the clinical experience the student will be able to:

1. Discuss the role of substance counselors/therapists and relate to the counseling role of the nurse.

2. Delineate the structure of the inpatient rehabilitation program for substance abusers.

What are significant components of the program?
How does the program relate to the theories of addictions/substance abuse?

What is the relationship between program elements and the 12-Step Program of AA/NA?

3. Describe the functions, protocols and significance of the substance abuse detoxification program and relate to treatment and recovery.

4. Identify the various roles of team members and the significance of these roles to client treatment.

5. Select two program activities that you observed and delineate three important elements about substance abuse treatment that you learned from these two activities.

6. Discuss the stressors that substance abusers face in the process of recovery.

7. Identify two principles of addiction/addictive behaviors that you would use in teaching clients about substance abuse based on this clinical experience.

8. List three attitudes or beliefs you held about substance abusers that have been changed or modified by this clinical experience.

**SUPPORT GROUP OBJECTIVES**

1. In your Clinical Journal, name the group, date attended, time length of the group and purpose of the support group. Use this format for each group attended.
2. Relate the function of the support group to three psychiatric principles utilizing concepts from Kneisl, & Trigoboff – Chapter 30 – Group & Family Interventions

3. Analyze the group functions:

   Did it meet the general criteria of a group?

   Did it provide support for the members?

   Were all members involved?

   What was the NATURE of the support offered?

   Was there a designated leader? If so describe the role of the leader.

4. How did the support group differ from the group processes or group therapies you have observed?

5. What did you learn about support groups in general? This group in particular?

6. What particular problems would prompt you to refer your patients to this support group?
CLINICAL JOURNAL CRITERIA

Name of student
Location of client contact
Name of preceptor
Date of client contact
Time spent with the client

Journal notes:
Rationale: Objectives and information required for each entry
Rationale: Record notes on therapeutic communication:

- Therapeutic communication is a complex skill learned with practice and by analyzing communication errors.
- Self-awareness and analysis improves communication techniques.

Objectives for recording journal notes in clinical experiences:
- Generate an account of interaction/s with clients along with the care-givers thoughts and feelings.
- Distinguish between therapeutic and non-therapeutic communication patterns.
- Use reflection and critical thinking to develop more effective and caring communication.
- Record experiences during the clinical for learning

Information to be included in documenting nurse-client interactions:

1. Demographic information listed at the top of the page.
2. Document highlights of the current session with the client. Include the emotions expressed by client and you.
3. Indicate positive and negative therapeutic communication styles used during the intervention. Describe verbal, non-verbal and meta-communication techniques utilized during the intervention by both you and the client.
4. Describe briefly what went well about the current session with the client. Include therapeutic communications used, results, your feelings and what you observed.
5. Describe briefly what did not go well about the current session with the client. Including therapeutic communications used, results, your feelings and what you observed. Describe briefly what you might have done to have the client session go better - be specific.
6. Describe the depth of assessment and evaluation (Syllabus, p. 52).
7. Analyze increased awareness and insight into your own behavior and knowledge of psychiatric clients.

TEACHING/LEARNING PLAN CRITERIA

The student will assess the learning need/s, experiential and emotional readiness of a patient or group of patients in the psychiatric setting. Based on that assessment a teaching plan will be developed and implemented within the clinical setting and a copy of the plan will be included in the Clinical Log.

The teaching/learning plan will be evaluated according to the following criteria:

0 = Unsatisfactory  2 = Acceptable
1 = Questionable     3 = Excellent

0123 Plan contains necessary identifying information - agency, title of teaching, learner/s involved
0123 Learner(s) need(s) is/are evident in description
0123 Experiential readiness of patient/s is summarized
0123 Emotional readiness of patient/s is described.
0123 Learning objectives are stated as outcomes
0123 Learning objectives are congruent with teaching
0123 Teaching methods and materials are identified
0123 Content is described with adequate detail
0123 Management of the learning environment is described
0123 Teaching actions are specific to content and teaching actions are distinguishable from one another
0123 Method used to evaluate learning is evident
0123 Visual aids are appropriate to the patient/s and setting
0123 Evaluation of teaching and patient learning are evident in the plan
0123 References are in APA format
0123 Teaching plan is prepared in proper form, correct spelling and free of errors.

Total Points ____________________

NURSING CARE PLAN
(Consult your clinical instructor)
# PROCESS RECORDING

**Student:**

**Patient Initials:**

**Patient Diagnosis:**

**Date of Interaction:**

<table>
<thead>
<tr>
<th>Patient (verbal/non-verbal communication)</th>
<th>Student Nurse (verbal/non-verbal communication)</th>
<th>Feelings (Feelings of student nurse during interaction)</th>
<th>Meta-Communication (verbal/non-verbal implied)</th>
<th>Insight (student nurse’s insight gained in communication)</th>
<th>Evaluation (evaluation for improving the communication)</th>
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